

CARRS SURVEILLANCE STUDY: COHORT-1

4th follow up questionnaire- Part I

| | |
|--|--|
| Cluster ID <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <i>clu_id</i> | Household ID <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <i>hhp_id</i> |
| Follow-up ID <input type="text"/> <input type="text"/> <input type="text"/> <i>fup_id</i> | Interviewer ID <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <i>iid</i> |
| Date of interview: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DD/ MM/ YY <i>doi</i> | Start Time (Hr:min) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> HR MIN <i>start_t</i> |

| Part-1 : Response and contact of the participant | | |
|--|---|--|
| 1. Does the participant agree to be interviewed? | <i>[Yes =1; No =2]</i> | <i>std_res</i> <input type="text"/> If '2', go to Q-4 |
| 2. If YES, what is the present address | Same as baseline survey/follow up 1, 2 & 3 <input type="text"/> Changed <input type="text"/> | <i>std_res_y</i> <input type="text"/> If '1' go to question-6 |
| 3. If changed, note the current address: <i>add_change</i> | | |

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--------------------------|--------------------------|---------------------------------------|---------------------------|--|----------|---|--------------------------|--------------|-------------------------|--------------------------|----------|---|--------------------------|----------|--|---|----------|---|--------------------------|----------|-----------------------|--------------------------|----------|-----------------------------------|--------------------------|----------|-----------|--------------------------|-----------|--------------------|
| <p>4. If NO, what is the reason for non-response?</p> | <table> <tr> <td>Shifted not traceable</td> <td>1</td> </tr> <tr> <td>Shifted, traceable but not interested</td> <td>2</td> </tr> <tr> <td>Shifted but not approachable/out of area range</td> <td>3</td> </tr> <tr> <td>Hard refusal</td> <td>4</td> </tr> <tr> <td>Soft refusal</td> <td>5</td> </tr> <tr> <td>Deceased</td> <td>6</td> </tr> <tr> <td>Could not complete this survey and will available for next year follow-up</td> <td>7</td> </tr> <tr> <td>Others</td> <td>8</td> </tr> </table> | Shifted not traceable | 1 | Shifted, traceable but not interested | 2 | Shifted but not approachable/out of area range | 3 | Hard refusal | 4 | Soft refusal | 5 | Deceased | 6 | Could not complete this survey and will available for next year follow-up | 7 | Others | 8 | <div> <input type="checkbox"/> std_res_n </div> <div> <p>If "8" please specify</p> <p>std_res_n_sp</p> </div> | | | | | | | | | | | | | | |
| Shifted not traceable | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Shifted, traceable but not interested | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Shifted but not approachable/out of area range | 3 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Hard refusal | 4 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Soft refusal | 5 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Deceased | 6 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Could not complete this survey and will available for next year follow-up | 7 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Others | 8 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <ul style="list-style-type: none"> If the answer in above question is 2, 4, 5 or 7 complete question number 5. If the answer in above question is 6; skip this questionnaire and please complete verbal autopsy form | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>5. If "Refused", Reasons for refusal:</p> | <table> <tr> <td>A. Not able to give time</td> <td><input type="checkbox"/></td> <td>ref_rsn1</td> </tr> <tr> <td>B. Interviews are lengthy</td> <td><input type="checkbox"/></td> <td>ref_rsn2</td> </tr> <tr> <td>C. Not interested in providing blood sample</td> <td><input type="checkbox"/></td> <td>ref_rsn3</td> </tr> <tr> <td>D. Too much blood drawn</td> <td><input type="checkbox"/></td> <td>ref_rsn4</td> </tr> <tr> <td>E. Not satisfied with the lab report</td> <td><input type="checkbox"/></td> <td>ref_rsn5</td> </tr> <tr> <td>F. Need more medical attention/medicines</td> <td><input type="checkbox"/></td> <td>ref_rsn6</td> </tr> <tr> <td>G. Do not see any benefit in participating in the study</td> <td><input type="checkbox"/></td> <td>ref_rsn7</td> </tr> <tr> <td>H. Do not feel secure</td> <td><input type="checkbox"/></td> <td>ref_rsn8</td> </tr> <tr> <td>I. Do not want to give any reason</td> <td><input type="checkbox"/></td> <td>ref_rsn9</td> </tr> <tr> <td>J. Others</td> <td><input type="checkbox"/></td> <td>ref_rsn10</td> </tr> </table> <p>If others: Please specify in detail:</p> <p>ref_rsn_sp</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> | A. Not able to give time | <input type="checkbox"/> | ref_rsn1 | B. Interviews are lengthy | <input type="checkbox"/> | ref_rsn2 | C. Not interested in providing blood sample | <input type="checkbox"/> | ref_rsn3 | D. Too much blood drawn | <input type="checkbox"/> | ref_rsn4 | E. Not satisfied with the lab report | <input type="checkbox"/> | ref_rsn5 | F. Need more medical attention/medicines | <input type="checkbox"/> | ref_rsn6 | G. Do not see any benefit in participating in the study | <input type="checkbox"/> | ref_rsn7 | H. Do not feel secure | <input type="checkbox"/> | ref_rsn8 | I. Do not want to give any reason | <input type="checkbox"/> | ref_rsn9 | J. Others | <input type="checkbox"/> | ref_rsn10 | <p>Yes=1; No=2</p> |
| A. Not able to give time | <input type="checkbox"/> | ref_rsn1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| B. Interviews are lengthy | <input type="checkbox"/> | ref_rsn2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| C. Not interested in providing blood sample | <input type="checkbox"/> | ref_rsn3 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| D. Too much blood drawn | <input type="checkbox"/> | ref_rsn4 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| E. Not satisfied with the lab report | <input type="checkbox"/> | ref_rsn5 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| F. Need more medical attention/medicines | <input type="checkbox"/> | ref_rsn6 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| G. Do not see any benefit in participating in the study | <input type="checkbox"/> | ref_rsn7 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| H. Do not feel secure | <input type="checkbox"/> | ref_rsn8 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| I. Do not want to give any reason | <input type="checkbox"/> | ref_rsn9 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| J. Others | <input type="checkbox"/> | ref_rsn10 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| Part 1A:- Details of contacts | |
|---|------------|
| 6. Name of the 1 st contact | cont1_name |
| Address of 1 st contact | cont1_add |
| Telephone number of 1 st contact | cont1_ph |
| 7. Name of the 2 nd contact | cont2_name |
| Address of 2 nd contact | cont2_add |
| Telephone number of 2 nd contact | cont2_ph |
| 8. Name of the Home Town contact | h_con_name |
| Address of Home Town contact | h_con_add |
| Telephone number of Home Town contact | h_con_ph |

CARRS SURVEILLANCE STUDY: COHORT-1

4th follow up questionnaire- Part II

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|---|---|----|---|-----------------------------------|---|--------------------------------|---|---|---|-----------------------------|---|---------------------------------|---|------------------------------------|---|-----------------------------------|---|------------|---|---------|---|--------|----|-----------------------------------|----|--|----|--|----|-----------------|----|
| Household ID :- <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | Participant ID :- <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CEB Code :- <input type="text"/> <input type="text"/> <input type="text"/> | Interviewer ID:- <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date of Interview:- <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> D D M M Y Y | Start Time:- <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Hour Minutes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SECTION 1 :- DEMOGRAPHIC AND SOCIOECONOMIC DETAILS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 1A :- DEMOGRAPHIC DETAILS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.1 For men, relationship with the female participant (Ask only to male participant) | <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">Not applicable (participant is female)</td> <td style="width: 10%; text-align: right;">99</td> <td rowspan="14" style="width: 30%; vertical-align: top; padding-left: 10px;"> <div style="text-align: center; color: #c00000;">rel_fem</div> <div style="text-align: center; margin-top: 10px;"><input type="text"/> <input type="text"/></div> <div style="text-align: center; margin-top: 10px;">If others (option 14), then specify</div> <div style="text-align: center; margin-top: 10px;">-----</div> <div style="text-align: center; color: #c00000;">rel_fem_sp</div> </td> </tr> <tr><td>Husband</td><td style="text-align: right;">1</td></tr> <tr><td>Father-in-law</td><td style="text-align: right;">2</td></tr> <tr><td>Son</td><td style="text-align: right;">3</td></tr> <tr><td>Father</td><td style="text-align: right;">4</td></tr> <tr><td>Grand father</td><td style="text-align: right;">5</td></tr> <tr><td>Brother-in-law (husband's brother)</td><td style="text-align: right;">6</td></tr> <tr><td>Brother-in-law (sister's husband)</td><td style="text-align: right;">7</td></tr> <tr><td>Son-in-law</td><td style="text-align: right;">8</td></tr> <tr><td>Brother</td><td style="text-align: right;">9</td></tr> <tr><td>Cousin</td><td style="text-align: right;">10</td></tr> <tr><td>No female participant is selected</td><td style="text-align: right;">11</td></tr> <tr><td>Female participant was adopted into the family</td><td style="text-align: right;">12</td></tr> <tr><td>Male participant was adopted into the family</td><td style="text-align: right;">13</td></tr> <tr><td>Others, specify</td><td style="text-align: right;">14</td></tr> </table> | Not applicable (participant is female) | 99 | <div style="text-align: center; color: #c00000;">rel_fem</div> <div style="text-align: center; margin-top: 10px;"><input type="text"/> <input type="text"/></div> <div style="text-align: center; margin-top: 10px;">If others (option 14), then specify</div> <div style="text-align: center; margin-top: 10px;">-----</div> <div style="text-align: center; color: #c00000;">rel_fem_sp</div> | Husband | 1 | Father-in-law | 2 | Son | 3 | Father | 4 | Grand father | 5 | Brother-in-law (husband's brother) | 6 | Brother-in-law (sister's husband) | 7 | Son-in-law | 8 | Brother | 9 | Cousin | 10 | No female participant is selected | 11 | Female participant was adopted into the family | 12 | Male participant was adopted into the family | 13 | Others, specify | 14 |
| Not applicable (participant is female) | 99 | <div style="text-align: center; color: #c00000;">rel_fem</div> <div style="text-align: center; margin-top: 10px;"><input type="text"/> <input type="text"/></div> <div style="text-align: center; margin-top: 10px;">If others (option 14), then specify</div> <div style="text-align: center; margin-top: 10px;">-----</div> <div style="text-align: center; color: #c00000;">rel_fem_sp</div> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Husband | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Father-in-law | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Son | 3 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Father | 4 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Grand father | 5 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Brother-in-law (husband's brother) | 6 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Brother-in-law (sister's husband) | 7 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Son-in-law | 8 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Brother | 9 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Cousin | 10 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| No female participant is selected | 11 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Female participant was adopted into the family | 12 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Male participant was adopted into the family | 13 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Others, specify | 14 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.2 What is your marital status ? | <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">Single</td> <td style="width: 10%; text-align: right;">1</td> <td rowspan="5" style="width: 30%; vertical-align: top; padding-left: 10px;"> <div style="text-align: center; color: #c00000;">mat_stat</div> <div style="text-align: center; margin-top: 10px;"><input type="text"/></div> <div style="text-align: center; margin-top: 10px;">If others (option 5), then specify</div> <div style="text-align: center; margin-top: 10px;">mat_stat_sp</div> <div style="text-align: center; margin-top: 10px;">-----</div> </td> </tr> <tr><td>Married</td><td style="text-align: right;">2</td></tr> <tr><td>Widow/Widower</td><td style="text-align: right;">3</td></tr> <tr><td>Separated/Divorced</td><td style="text-align: right;">4</td></tr> <tr><td>Others</td><td style="text-align: right;">5</td></tr> </table> | Single | 1 | <div style="text-align: center; color: #c00000;">mat_stat</div> <div style="text-align: center; margin-top: 10px;"><input type="text"/></div> <div style="text-align: center; margin-top: 10px;">If others (option 5), then specify</div> <div style="text-align: center; margin-top: 10px;">mat_stat_sp</div> <div style="text-align: center; margin-top: 10px;">-----</div> | Married | 2 | Widow/Widower | 3 | Separated/Divorced | 4 | Others | 5 | | | | | | | | | | | | | | | | | | | | |
| Single | 1 | <div style="text-align: center; color: #c00000;">mat_stat</div> <div style="text-align: center; margin-top: 10px;"><input type="text"/></div> <div style="text-align: center; margin-top: 10px;">If others (option 5), then specify</div> <div style="text-align: center; margin-top: 10px;">mat_stat_sp</div> <div style="text-align: center; margin-top: 10px;">-----</div> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Married | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Widow/Widower | 3 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Separated/Divorced | 4 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Others | 5 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 1B :- SOCIO-ECONOMIC DETAILS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.3 Number of years of formal education* <i>*The total number of years the participant spent in any educational institution (schools, colleges, religious schools etc.)</i> | <div style="text-align: center; color: #c00000;">for_edu</div> <div style="text-align: center; margin-top: 10px;"><input type="text"/> <input type="text"/></div> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.4 Educational status (highest attained degree) <i>* A person who can both read and write with understanding in any language without any formal education or passed any minimum educational standard.</i> <i>** A person who can neither read nor write or can only read but cannot write in any language</i> | <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">Professional degree/post graduate</td> <td style="width: 10%; text-align: right;">1</td> <td rowspan="8" style="width: 30%; vertical-align: top; padding-left: 10px;"> <div style="text-align: center; color: #c00000;">edu_stat</div> <div style="text-align: center; margin-top: 10px;"><input type="text"/> <input type="text"/></div> <div style="text-align: center; margin-top: 10px;">If others (option 8), then specify</div> <div style="text-align: center; margin-top: 10px;">-----</div> <div style="text-align: center; color: #c00000;">edu_stat_sp</div> </td> </tr> <tr><td>Graduate (B.A/B.Sc/B.Com/Diploma)</td><td style="text-align: right;">2</td></tr> <tr><td>Secondary School /Intermediary</td><td style="text-align: right;">3</td></tr> <tr><td>(ITI course ,class XII/X or Intermediate)</td><td></td></tr> <tr><td>High school (class V to IX)</td><td style="text-align: right;">4</td></tr> <tr><td>Primary School (up to Class IV)</td><td style="text-align: right;">5</td></tr> <tr><td>*Literate, no formal education</td><td style="text-align: right;">6</td></tr> <tr><td>**Illiterate</td><td style="text-align: right;">7</td></tr> <tr><td>Others</td><td style="text-align: right;">8</td></tr> </table> | Professional degree/post graduate | 1 | <div style="text-align: center; color: #c00000;">edu_stat</div> <div style="text-align: center; margin-top: 10px;"><input type="text"/> <input type="text"/></div> <div style="text-align: center; margin-top: 10px;">If others (option 8), then specify</div> <div style="text-align: center; margin-top: 10px;">-----</div> <div style="text-align: center; color: #c00000;">edu_stat_sp</div> | Graduate (B.A/B.Sc/B.Com/Diploma) | 2 | Secondary School /Intermediary | 3 | (ITI course ,class XII/X or Intermediate) | | High school (class V to IX) | 4 | Primary School (up to Class IV) | 5 | *Literate, no formal education | 6 | **Illiterate | 7 | Others | 8 | | | | | | | | | | | | |
| Professional degree/post graduate | 1 | <div style="text-align: center; color: #c00000;">edu_stat</div> <div style="text-align: center; margin-top: 10px;"><input type="text"/> <input type="text"/></div> <div style="text-align: center; margin-top: 10px;">If others (option 8), then specify</div> <div style="text-align: center; margin-top: 10px;">-----</div> <div style="text-align: center; color: #c00000;">edu_stat_sp</div> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Graduate (B.A/B.Sc/B.Com/Diploma) | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Secondary School /Intermediary | 3 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (ITI course ,class XII/X or Intermediate) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| High school (class V to IX) | 4 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Primary School (up to Class IV) | 5 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *Literate, no formal education | 6 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Illiterate | 7 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Others | 8 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| | | |
|---|--|---|
| 1.5 What is your employment status? | Employed 1 Student 2 Housewife 3 Retired 4 Un-employed 5 Others 6 | <input type="text"/> emp_stat If other (option 6), then specify emp_stat_sp _____ |
| 1.6 If "Employed" , what is your current occupation? [Use nearest applicable employment codes given below] | | <input type="text"/> emp_cur_occ Please mention emp_cur_occ_sp _____ |
| Coding list for employment (for Q1.6) Professional, big business ,landlord (> 10 acre) , university teacher, class 1IAS/services officer, lawyer 1 Trained, clerical, medium business owner, middle level farmer (2-10 acre) , teacher, maintenance (in-charge), personnel manager 2 Skilled manual laborer, small business owner, small farmer (<1 acre) 3 Semi-skilled manual laborer, marginal land owner, rickshaw driver, army jawan, carpenter, fitter 4 Unskilled manual laborer, landless laborer 5 | | |
| 1.7 Have you been involved in any other occupation during past ten years? | Yes 1 No 2 | <input type="text"/> oth_occ If "2" go to Q.1.9 |
| 1.8 If "Yes" , what was your previous occupation? [Use nearest applicable employment codes given below] | | <input type="text"/> pre_occ Please mention pre_occ_sp _____ |
| Coding list for employment (for Q1.8) Professional, big business ,landlord (> 10 acre) , university teacher, class 1IAS/services officer, lawyer 1 Trained, clerical, medium business owner, middle level farmer (2-10 acre) , teacher, maintenance (in-charge), personnel manager 2 Skilled manual laborer, small business owner, small farmer (<1 acre) 3 Semi-skilled manual laborer, marginal land owner, rickshaw driver, army jawan, carpenter, fitter 4 Unskilled manual laborer, landless laborer 5 | | |
| 1.9 What is your total household income per month? [Please include income from all member who contribute to the household] | <3000 1 3000-10,000 2 10,001-20,000 3 20,001-30,000 4 30,001-40,000 5 40,001-50,000 6 >50,000 7 Refused 8 Don't know 9 | <input type="text"/> hh_income |
| 1.10 Do you have a separate room for cooking (Kitchen)? | Yes 1 No 2 | <input type="text"/> sep_kit |
| 1.11 What is the fuel used for cooking? [If more than one source is used then note the source that is most commonly used] | Coal/charcoal/kerosene 1 Induction/Electricity/gas(LPG)/solar/CNG(IGL) 2 Wood/dung 3 Others 4 | <input type="text"/> fuel_cook If others (option 4), then sepcify fuel_cook_sp _____ |

| | | |
|--|---|--|
| <p>1.12 What is the source of drinking water used at home?</p> <p>[If more than one source is used then note the source that is most commonly used]</p> | <p>Public source 1</p> <p>Private source(Shared) 2</p> <p>Private source(Own) 3</p> <p>Bottled water 4</p> <p>Purified tap water 5</p> <p>Others 6</p> | <p><input type="text"/> drink_water</p> <p>If others (option 6), then sepcify</p> <p><input type="text"/> drink_water_sp</p> |
| <p>1.13 What is the toilet facility you use?</p> | <p>Public toilet 1</p> <p>Shared toilet 2</p> <p>Own flush toilet 3</p> <p>Others 4</p> | <p><input type="text"/> toilet_fac</p> <p>If others (option 4), then sepcify</p> <p><input type="text"/> toilet_fac_sp</p> |
| <p>1.14 Which of the following do you own?</p> <p>[Yes=1;No=2]</p> | <p>Television</p> <p>Refrigerator</p> <p>Washing machine</p> <p>Microwave/OTG</p> <p>Mixer-grinder</p> <p>Mobile phone</p> <p>DVD player</p> <p>Computer/Laptop</p> <p>Car</p> <p>Motor Cycle/ Scooter</p> <p>Bicycle</p> | <p><input type="text"/> own_tv</p> <p><input type="text"/> own_fridge</p> <p><input type="text"/> own_wash</p> <p><input type="text"/> own_mic</p> <p><input type="text"/> own_mix</p> <p><input type="text"/> own_mob</p> <p><input type="text"/> own_dvd</p> <p><input type="text"/> own_com</p> <p><input type="text"/> own_car</p> <p><input type="text"/> own_bike</p> <p><input type="text"/> own_bicy</p> |

SECTION 2 :- TOBACCO and ALCOHOL CONSUMPTION AND PHYSICAL ACTIVITY

PART 2A:- TOBACCO AND ALCOHOL USE

| | | | |
|--|---|--|---|
| 2.1 Do you currently consume tobacco? (within last 1 year) | Yes No | 1 2 | <input type="checkbox"/> con_tob If 2, skip to Q2.3 |
| 2.2 If yes, how often? [Regularly (≥once a week)=1; Occasionally (<once a week) =2; No=3] | Smoking form <input type="checkbox"/> hw_smk | Chewed form <input type="checkbox"/> hw_chw | Any other form <input type="checkbox"/> hw_ot |
| 2.3 Have you used alcoholic beverages in last one year? | Yes No Don't remember | 1 2 3 | <input type="checkbox"/> con_alc If 2& 3 go to Part 2B |
| 2.4 If yes, how often did you consume? | Regularly(≥ once a week) Occasionally(Less than once a week) | 1 2 | <input type="checkbox"/> hw_alc |

PART 2B :- PHYSICAL ACTIVITY

Next, I am going to ask you about the time you spend doing different types of physical activity in a typical week. Please answer these questions even if you do not consider yourself to be a physically active person.

Think first about the time you spend doing work. Think of work as the things that you have to do such as paid or unpaid work, study/training, household chores, harvesting food/crops, fishing, seeking employment. In answering the following questions 'vigorous-intensity activities' are activities that require hard physical effort and cause large increases in breathing or heart rate, 'moderate-intensity activities' are activities that require moderate physical effort and cause small increases in breathing or heart rate.

| Questions | | Response | |
|---------------------------------|---|--------------------|---|
| 2B-I: - ACTIVITY AT WORK | | | |
| 2.5 | <p>Does your work involve vigorous-intensity activity that causes large increases in breathing or heart rate like <i>[carrying or lifting heavy loads, digging or construction work]</i> for at least 10 minutes continuously? (USE SHOWCARD)</p> <p>Activities are regarded as vigorous intensity if they cause as large increase in breathing and/or heart rate</p> <p><i>[Sawing hardwood, forestry (cutting, chopping, carrying wood, ploughing, cutting crops (sugarcane), digging, grinding (with pestle), laboring (shoveling sand, loading furniture(stoves, fridge), instructing sports aerobics, cycle rickshaw driving]</i></p> <p>Think only about those physical activities that you do for <u>at least 10 minutes</u> at a time.</p> | Yes 1 No 2 | <div> <input type="text"/> viact </div> <p>If “2”, go to Q.2.8</p> |
| 2.6 | <p>In a typical week (7 days), on how many days do you do vigorous-intensity activities as part of your work?</p> <p>“Typical week” means a week when a person is doing vigorous intensity activities and not an average over a period.</p> <p>“Typical week” means a week when the participant is engaged in his/her usual activities.</p> | No. of days | <div> <input type="text"/> viact_dy </div> |
| 2.7 | <p>How much time do you spend doing vigorous-intensity activities at work on a typical day?</p> <p>Ask the participant to think of a typical day he/she can recall easily in which he/she engaged in vigorous-intensity activities at work.</p> <p>Think of one day you can recall easily. Consider only those activities undertaken continuously for 10 minutes or more.</p> <p>Probe very high response (over 4 hours) to verify</p> | Hours : Minutes | <div> <div> <input type="text"/> <input type="text"/> </div> <div> <input type="text"/> <input type="text"/> </div> <div> Hours : Minutes viact_hr viact_min </div> </div> |

| | | | |
|--|---|-------------------------------|---|
| 2.8 | <p>Does your work involve moderate-intensity activity that causes small increases in breathing or heart rate such as brisk walking [or carrying light loads] for at least 10 minutes continuously? (USE SHOWCARD)</p> <p>Activities are regarded as moderate intensity if they cause as small increase in breathing and/or heart rate</p> <p>[washing (bating and brushing carpets, wringing clothes (by hand), gardening, digging dry soil (with spade), weaving, woodwork (chiseling, sawing, softwood), mixing cement (with shovel), laboring (pushing loaded wheelbarrow, operating jackhammer, walking with load on head, drawing water, tending animals)]</p> <p>Do not include walking. Again, think about only those physical activities that you did for at least 10 minutes at a time.</p> | <p>Yes 1</p> <p>No 2</p> | <p>miact <input type="text"/></p> <p>If "2", go to Q.2.11</p> |
| 2.9 | <p>In a typical week (7 days), on how many days do you do moderate-intensity activities as part of your work?</p> | No. of days | <p>miact_dy <input type="text"/></p> |
| 2.10 | <p>How much time do you spend doing moderate-intensity activities at work on a typical day?</p> <p>Think of one day you can recall easily. Consider only those activities undertaken continuously for 10 minutes or more.</p> <p>"Typical day" means a day when the participant is engaged in his/her usual activities.</p> <p>Probe very high responses (over 4 hrs) to verify</p> | <p>Hours :</p> <p>Minutes</p> | <p><input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/></p> <p>Hours : Minutes</p> <p>miact_hr miact_min</p> |
| 2B-II: - Travel to and from places | | | |
| <p>The next questions exclude the physical activities at work that you have already mentioned.</p> <p>Now I would like to ask you about the usual way you travel to and from places. For example: to work, for shopping, to market, to place of worship.</p> <p>The introductory statement to the following questions on transport-related physical activity is very important. It asks and helps the participant to now think about how they travel around getting from place-to-place. This statement should not be omitted.</p> | | | |
| 2.11 | <p>Do you walk or use a bicycle (<i>pedal cycle</i>) for at least 10 minutes continuously to get to and from places?</p> | <p>Yes 1</p> <p>No 2</p> | <p><input type="text"/> use_cyl</p> <p>If "2", go to Q.2.14</p> |
| 2.12 | <p>In a typical week (7 days), on how many days do you walk or bicycle for at least 10 minutes continuously to get to and from places?</p> | No. of days | <p><input type="text"/> use_cyl_dy</p> |
| 2.13 | <p>How much time do you spend walking or bicycling for travel on a typical day?</p> <p>Ask the participant to think of a typical day he/she can recall easily in which he/she engaged in transport-related activities.</p> <p>Think of one day you can recall easily. Consider the total amount of time walking or bicycling for trips of 10 minutes or more.</p> <p>Probe very high responses (over 4 hrs) to verify.</p> | <p>Hours:</p> <p>Minutes</p> | <p><input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/></p> <p>Hours : Minutes</p> <p>use_cyl_hr use_cyl_min</p> |
| 2B-III: - Recreational activities | | | |
| <p>The next questions exclude the work and transport activities that you have already mentioned.</p> <p>Now I would like to ask you about sports, fitness and recreational activities (leisure).</p> | | | |
| 2.14 | <p>Do you do any vigorous-intensity sports, fitness or recreational (<i>leisure</i>) activities that cause large increases in breathing or heart rate like [running or football] for at least 10 minutes continuously? (USE SHOWCARD)</p> <p>Activities are regarded as vigorous intensity if they cause a large increase in breathing and/or heart rate.</p> <p>[Badminton, tennis, high-impact aerobics, aqua aerobic, fast swimming]</p> | <p>Yes 1</p> <p>No 2</p> | <p>vispo <input type="text"/></p> <p>If "2", go to Q.2.17</p> |

| | | | |
|--|---|---|---|
| 2.15 | In a typical week (7 days) , on how many days do you do vigorous-intensity sports, fitness or recreational (<i>leisure</i>) activities? | No. of days | vispo_dy <input type="text"/> |
| 2.16 | How much time do you spend doing vigorous-intensity sports, fitness or recreational activities on a typical day? Ask the participant to think of a typical day he/she can recall easily in which he/she engaged in recreational vigorous-intensity activities. Think of one day you can recall easily. Consider the total amount of time doing vigorous recreational activities for periods of 10 minutes or more. Probe very high responses (over 4 hrs). | Hours : Minutes | <input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> Hours : Minutes vispo_hr vispo_min |
| 2.17 | Do you do any moderate-intensity sports, fitness or recreational (<i>leisure</i>) activities that causes a small increase in breathing or heart rate such as brisk walking, <i>cycling</i> , <i>swimming</i> , <i>volleyball</i> for at least 10 minutes continuously? (USE SHOWCARD) Activities are regarded as moderate intensity if they cause a small increase in breathing and/or heart rate. [Cycling, jogging, dancing, horse-riding, yoga, low-impact aerobics, cricket] | Yes 1 No 2 | mispo <input type="text"/> If "2", go to Q.2.20 |
| 2.18 | In a typical week (7 days) , on how many days do you do moderate-intensity sports, fitness or recreational (<i>leisure</i>) activities? | No. of days | mispo_dy <input type="text"/> |
| 2.19 | How much time do you spend doing moderate-intensity sports, fitness or recreational (<i>leisure</i>) activities on a typical day ? Ask the participant to think of a typical day he/she can recall easily in which he/she engaged in recreational moderate-intensity activities. Think of one day you can recall easily. Consider the total amount of time doing moderate recreational activities for periods of 10 minutes or more. Probe very high responses (over 4 hrs). | Hours : Minutes | <input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> Hours : Minutes mispo_hr mispo_min |
| 2B-IV: - Sedentary behavior | | | |
| The following question is about sitting or reclining at work, at home, getting to and from places, or with friends including time spent [sitting at a desk, sitting with friends, travelling in car, bus, train, reading, playing cards or watching television], but do not include time spent sleeping. (USE SHOWCARD) | | | |
| | | sit_hr sit_min | |
| 2.20 | How much time do you usually spend sitting or reclining on a typical day ? | Hours : Minutes | <input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> Hours : Minutes |
| 2.21 | How many hours/ minutes do you spend sitting/reclining in each of the following on a typical day ? | A. At work at the desk <small>sit_dsk_hr</small> | <input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> Hours : Minutes <small>sit_dsk_min</small> |
| | | B. In class during lectures <small>sit_clas_hr</small> | <input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> Hours : Minutes <small>sit_clas_min</small> |
| | | C. During travel (driving, traffic jams, bus, car, train, metro) <small>sit_trl_hr</small> | <input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> Hours : Minutes <small>sit_trl_min</small> |
| | | AT HOME | |

| | | | |
|------|--|--|--|
| | | D. During watching television | <div> <div>Hours</div> <div>Minutes</div> </div> <div> <div>sit_tv_hr</div> <div>sit_tv_min</div> </div> |
| | | E. In front of a computer | <div> <div>Hours</div> <div>Minutes</div> </div> <div> <div>sit_com_hr</div> <div>sit_com_min</div> </div> |
| | | F. Any other (chatting, playing cards etc.) | <div> <div>Hours</div> <div>Minutes</div> </div> <div> <div>sit_ot_hr</div> <div>sit_ot_min</div> </div> |
| 2.22 | For how long you stand in a typical day? (Calculate only if the standing is more than 10 minutes continuously) | Hours : Minutes | <div> <div>std_hr</div> <div>std_min</div> </div> <div> <div>Hours</div> <div>Minutes</div> </div> |
| 2.23 | Is there a park/open space/garden/children play ground near your house? | Yes 1 No 2 | <div> <div>prk_hse</div> </div> <p>If 2, skip to Section 3</p> |
| 2.24 | If yes, in a typical week do you use the park/ open space/garden/ children playground? | Yes 1 No 2 | <div> <div>use_prk</div> </div> <p>If 2, skip to Section 3</p> |
| 2.25 | If yes, what do you use it for? | A. Walking/Yoga/Jogging/Sports/other exercises | <p>Yes=1; No=2</p> <div> <div>prk_jog</div> </div> |
| | | B. Sitting/Socializing/Meditation/playing with or supervising kids | <div> <div>prk_sit</div> </div> |
| | | C. Others | <div> <div>prk_ot</div> </div> <p>prk_ot_sp specify</p> |

| SECTION– 3:MEDICAL HISTORY (CARDIO METABOLIC DISEASES AND THEIR RISK FACTORS) | | | |
|--|---|--|---|
| PART 3A: DISEASE SPECIFIC QUESTIONS | | | |
| 3A-I: Fill this section if the answer for high blood pressure/ high blood sugar/high blood cholesterol is “YES” in PART 3A-I, Q.3.1. If the answer is ‘YES’ to any of the choices in Q. 3.1, then go to Q.3.2. ‘OTHERWISE’ skip the entire section and go to 3A-II <i>*Exclude pregnancy induced Hypertension and High Blood Sugar</i> | | | |
| 3A-I: HYPERTENSION (High Blood Pressure)/DIABETES (High Blood Sugar)/ HYPERLIPIDEMIA (High Blood Cholesterol) | | | |
| | Hypertension (High Blood Pressure)* | Diabetes (High Blood Sugar)* | Hyperlipidemia (High Blood Cholesterol) |
| 3.1 Have you EVER been told by a doctor that you have any of the following diseases? [Yes =1; No =2; Don’t know=3] | hbp_dis <input style="width: 30px; height: 20px;" type="text"/> | <input style="width: 30px; height: 20px;" type="text"/> dia_dis | <input style="width: 30px; height: 20px;" type="text"/> hyle_dis |
| 3.2 SINCE HOW MANY YEARS have you had Hypertension/ Diabetes/ Hyperlipidemia? | Duration in Years /Month hbp_yr <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> Years hbp_mon <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> Months | Duration in Years /Month dia_yr <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> Years dia_mon <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> Months | Duration in Years /Month Years <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> hyle_yr Months <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> hyle_mon |
| 3.3 What treatment are you taking for it currently? [Yes=1; No=2] Prescribed dietary modification Prescribed physical exercise Traditional medicine/Therapy** other than yoga Allopathic drugs(English/modern) Yoga | hbp_trt_diet <input style="width: 30px; height: 20px;" type="text"/> hbp_trt_exe <input style="width: 30px; height: 20px;" type="text"/> hbp_trt_trad <input style="width: 30px; height: 20px;" type="text"/> hbp_trt_all <input style="width: 30px; height: 20px;" type="text"/> hbp_trt_yoga <input style="width: 30px; height: 20px;" type="text"/> | dia_trt_diet <input style="width: 30px; height: 20px;" type="text"/> dia_trt_exe <input style="width: 30px; height: 20px;" type="text"/> dia_trt_trad <input style="width: 30px; height: 20px;" type="text"/> dia_trt_all <input style="width: 30px; height: 20px;" type="text"/> dia_trt_yoga <input style="width: 30px; height: 20px;" type="text"/> | hyle_trt_diet <input style="width: 30px; height: 20px;" type="text"/> hyle_trt_exe <input style="width: 30px; height: 20px;" type="text"/> hyle_trt_trad <input style="width: 30px; height: 20px;" type="text"/> hyle_trt_all <input style="width: 30px; height: 20px;" type="text"/> hyle_trt_yoga <input style="width: 30px; height: 20px;" type="text"/> |
| *Traditional medicine/therapy include Ayurveda, Unani, Homeopathy, Tibetan, Naturopathy, Meditation | | | |
| 3A-II: HEART DISEASE | | | |
| 3.4 Have you EVER been told by a doctor that you have heart disease? [Yes=1 ; No=2; Don’t know=3] | <input style="width: 30px; height: 20px;" type="text"/> hrt_dis If “2” or “3” skip to 3A-III | | |
| 3.5 What did the doctor say it was? [Yes=1; No=2; Don’t know/Not sure=3] | <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> A. Heart attack B. Angina C. Heart failure D. Valve disease E. Hole in the heart F. Not informed about the nature of the problem G. Others </div> <div style="width: 35%;"> <input style="width: 30px; height: 20px;" type="text"/> dr_hrtatc <input style="width: 30px; height: 20px;" type="text"/> dr_ang <input style="width: 30px; height: 20px;" type="text"/> dr_hrtfail <input style="width: 30px; height: 20px;" type="text"/> dr_vadis <input style="width: 30px; height: 20px;" type="text"/> dr_hol <input style="width: 30px; height: 20px;" type="text"/> dr_noinform <input style="width: 30px; height: 20px;" type="text"/> dr_ot If “1” for other, please specify <input style="width: 100px; height: 20px;" type="text"/> dr_ot_sp </div> </div> | | |
| If “1” for heart attack then fill the following questions otherwise skip to Q3.14 | | | |

| | | | |
|--|--|--|--|
| 3.6 If heart attack, how many attacks you have had till now? | <input type="text"/> <input type="text"/> hw_mattack | | |
| | First event (Heart attack) | Second event (Heart attack) | Third event (Heart attack) |
| 3.7 Date of heart attack | <input type="text"/> <input type="text"/> atk_1st_mon <input type="text"/> <input type="text"/> atk_1st_yr Month Year | <input type="text"/> <input type="text"/> atk_2nd_mon <input type="text"/> <input type="text"/> atk_2nd_yr Month Year | <input type="text"/> <input type="text"/> atk_3rd_mon <input type="text"/> <input type="text"/> atk_3rd_yr Month Year |
| 3.8 What symptoms did you have during this event? A. Chest pain/ discomfort >20 minutes B. Pain radiating to arm, shoulder or neck C. Sweating or vomiting D. Others | [Yes=1; No=2; Not sure=3] <input type="text"/> sym_che_pain1 <input type="text"/> sym_pain_arm1 <input type="text"/> sym_swt_vom1 <input type="text"/> sym_ot1 If others please specify sym_ot_sp1 | [Yes=1; No=2; Not sure=3] <input type="text"/> sym_che_pain2 <input type="text"/> sym_pain_arm2 <input type="text"/> sym_swt_vom2 <input type="text"/> sym_ot2 If others please specify sym_ot_sp2 | [Yes=1; No=2; Not sure=3] <input type="text"/> sym_che_pain3 <input type="text"/> sym_pain_arm3 <input type="text"/> sym_swt_vom3 <input type="text"/> sym_ot3 If others please specify sym_ot_sp3 |
| 3.9 How long these symptoms were present before you met doctor? | <input type="text"/> <input type="text"/> sym_met_dr_wk1 <input type="text"/> <input type="text"/> sym_met_dr_hr1 <input type="text"/> <input type="text"/> sym_met_dr_dy1 Weeks Days Hours | <input type="text"/> <input type="text"/> sym_met_dr_wk2 <input type="text"/> <input type="text"/> sym_met_dr_hr2 <input type="text"/> <input type="text"/> sym_met_dr_dy2 Weeks Days Hours | <input type="text"/> <input type="text"/> sym_met_dr_wk3 <input type="text"/> <input type="text"/> sym_met_dr_hr3 <input type="text"/> <input type="text"/> sym_met_dr_dy3 Weeks Days Hours |
| 3.10 Were you hospitalized for this event? [Yes=1; No=2] | <input type="text"/> hosp_event1 | <input type="text"/> hosp_event2 | <input type="text"/> hosp_event3 |
| If yes, go to Q3.11 otherwise skip to Q3.12 | | | |
| 3.11 If hospitalized for this event, what procedure did they do in the hospital? Angioplasty (Stent)=1 Coronary Artery bypass surgery (Bypass) =2 Thrombolytic therapy =3 Only medicines =4 Others=5 | <input type="text"/> hosp_pro1 If others please specify hosp_pro_sp1 | <input type="text"/> hosp_pro2 If others please specify hosp_pro_sp2 | <input type="text"/> hosp_pro3 If others please specify hosp_pro_sp3 |
| If Q3.11 is filled then skip to Q3.13 | | | |
| 3.12 If not hospitalized for this event, where did you take treatment? Visited allopathic doctor and took treatment as outpatient=1 Visited Ayurveda/homeopathic/other traditional healers =2 Others=3 | <input type="text"/> wh_tk_trt1 If others please specify wh_tk_trt_sp1 | <input type="text"/> wh_tk_trt2 If others please specify wh_tk_trt_sp2 | <input type="text"/> wh_tk_trt3 If others please specify wh_tk_trt_sp3 |

| | | | |
|---|--|---|---|
| <p>3.13 Ask the participant whether they have medical records related to the events and current medication and treatment. If so, please take pictures of every page of the record.</p> <p>A. Discharge reports B. Consultant notes C. Prescription notes D. ECG E. Lab reports F. Other</p> | <p>[Yes=1; No=2]</p> <div> <input type="checkbox"/> hrt_rec_disrepo1 <input type="checkbox"/> hrt_rec_conote1 <input type="checkbox"/> hrt_rec_pres1 <input type="checkbox"/> hrt_rec_ecg1 <input type="checkbox"/> hrt_rec_lab1 <input type="checkbox"/> hrt_rec_ot1 </div> <p>If others please specify hrt_rec_otsp1</p> | <p>[Yes=1; No=2]</p> <div> <input type="checkbox"/> hrt_rec_disrepo2 <input type="checkbox"/> hrt_rec_conote2 <input type="checkbox"/> hrt_rec_pres2 <input type="checkbox"/> hrt_rec_ecg2 <input type="checkbox"/> hrt_rec_lab2 <input type="checkbox"/> hrt_rec_ot2 </div> <p>If others please specify hrt_rec_otsp2</p> | <p>[Yes=1; No=2]</p> <div> <input type="checkbox"/> hrt_rec_disrepo3 <input type="checkbox"/> hrt_rec_conote3 <input type="checkbox"/> hrt_rec_pres3 <input type="checkbox"/> hrt_rec_ecg3 <input type="checkbox"/> hrt_rec_lab3 <input type="checkbox"/> hrt_rec_ot3 </div> <p>If others please specify hrt_rec_otsp3</p> |
| <p>3.14 Are you taking any treatment for heart disease currently?</p> <p>[Yes=1; No=2]</p> | <div> <p>A. Allopathic drugs (English /modern)</p> <p>B. Traditional medicine (other than Yoga)</p> <p>C. Yoga</p> <p>D. Others</p> </div> <div> <input type="checkbox"/> cur_trt_all <input type="checkbox"/> cur_trt_trad <input type="checkbox"/> cur_trt_yoga <input type="checkbox"/> cur_trt_ot </div> <p>If others please specify cur_trt_otsp</p> | | |
| <p>3.15 For all participants: Have you ever undergone coronary angioplasty or stent? (This is a procedure to put stent in the heart blood vessels to destroy clots)</p> | <div> <p>Yes 1</p> <p>No 2</p> </div> <div> <input type="checkbox"/> ever_angio </div> <p>If "2" skip to 3A-III</p> | | |
| <p>3.16 If yes, when did you have latest procedure? lst_prc_mon</p> | <div> <input type="text"/> <input type="text"/> Months <input type="text"/> <input type="text"/> Years </div> <p>lst_prc_yr</p> | | |
| <p>3A-III: STROKE (Paralytic attack)</p> | | | |
| <p>3.17 Have you EVER been told by a doctor that you have stroke (Paralytic attack)?</p> <p>[Yes=1 ; No=2; Don't know=3]</p> | <div> <input type="checkbox"/> stroke </div> <p>If "2" or "3" skip to 3A-IIIa</p> | | |
| <p>3.18 If yes, how many times?</p> | <p>Number of times <input type="text"/> <input type="text"/> str_time</p> | | |
| | <p>First Stroke</p> | <p>Second Stroke</p> | <p>Third Stroke</p> |
| <p>3.19 Date of the stroke</p> | <p>str_mon1 str_yr1</p> <div> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </div> <p>Month Year</p> | <p>str_mon2 str_yr2</p> <div> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </div> <p>Month Year</p> | <p>str_mon3 str_yr3</p> <div> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </div> <p>Month Year</p> |

| | | | |
|--|--|--|--|
| <p>3.20 What symptoms did you experience?</p> <p>A. Did you become unconscious or drowsy?</p> <p>B. Was there loss of vision?</p> <p>C. Was there weakness in face or limbs?</p> <p>D. Was there weakness in on limb/half of the body?</p> <p>E. Was there difficulty in speaking?</p> <p>F. Was there disturbances of balance or walking?</p> <p>G. Was there trauma to the head or neck?</p> | <p>[Yes= 1; No= 2; Not sure/ Don't remember=3]</p> <p><input type="checkbox"/> sym_uncons1</p> <p><input type="checkbox"/> sym_los_vers1</p> <p><input type="checkbox"/> sym_wk_fe1</p> <p><input type="checkbox"/> sym_wk_by1</p> <p><input type="checkbox"/> sym_dif_spk1</p> <p><input type="checkbox"/> sym_disl_wk1</p> <p><input type="checkbox"/> sym_trma1</p> | <p>[Yes= 1; No= 2; Not sure/ Don't remember=3]</p> <p><input type="checkbox"/> sym_uncons2</p> <p><input type="checkbox"/> sym_los_vers2</p> <p><input type="checkbox"/> sym_wk_fe2</p> <p><input type="checkbox"/> sym_wk_by2</p> <p><input type="checkbox"/> sym_dif_spk2</p> <p><input type="checkbox"/> sym_disl_wk2</p> <p><input type="checkbox"/> sym_trma2</p> | <p>[Yes= 1; No= 2; Not sure/ Don't remember=3]</p> <p><input type="checkbox"/> sym_uncons3</p> <p><input type="checkbox"/> sym_los_vers3</p> <p><input type="checkbox"/> sym_wk_fe3</p> <p><input type="checkbox"/> sym_wk_by3</p> <p><input type="checkbox"/> sym_dif_spk3</p> <p><input type="checkbox"/> sym_disl_wk3</p> <p><input type="checkbox"/> sym_trma3</p> |
| <p>If "2" or "3" in all the boxes skip to Q3.22</p> | | | |
| <p>3.21 Was duration of any symptoms > 24 hours?</p> | <p>[Yes= 1; No= 2; Not sure/ Don't remember=3]</p> <p><input type="checkbox"/> sym_24hr1</p> | <p>[Yes= 1; No= 2; Not sure/ Don't remember=3]</p> <p><input type="checkbox"/> sym_24hr2</p> | <p>[Yes= 1; No= 2; Not sure/ Don't remember=3]</p> <p><input type="checkbox"/> sym_24hr3</p> |
| <p>3.22 Who diagnosed the stroke?</p> <p>MBBS doctor 1</p> <p>Ayurveda/homeopathic/traditional healer 2</p> <p>Others 3</p> <p>Not sure/ Don't remember 4</p> | <p><input type="checkbox"/> dias_str1</p> <p>If others please specify</p> <p><input type="text"/> dias_str_sp1</p> | <p><input type="checkbox"/> dias_str2</p> <p>If others please specify</p> <p><input type="text"/> dias_str_sp2</p> | <p><input type="checkbox"/> dias_str3</p> <p>If others please specify</p> <p><input type="text"/> dias_str_sp3</p> |
| <p>3.23 Were you hospitalized for this stroke?</p> | <p>[Yes= 1; No= 2; Not sure/ Don't remember=3]</p> <p><input type="checkbox"/> hosp_str1</p> | <p>[Yes= 1; No= 2; Not sure/ Don't remember=3]</p> <p><input type="checkbox"/> hosp_str2</p> | <p>[Yes= 1; No= 2; Not sure/ Don't remember=3]</p> <p><input type="checkbox"/> hosp_str3</p> |
| <p>If "2" skip to Q3.25 and if "3" skip to Q3.26</p> | | | |
| <p>3.24 If hospitalized for this stroke, was CT scan or MRI done?</p> | <p>[Yes= 1; No= 2; Not sure/ Don't remember=3]</p> <p><input type="checkbox"/> str_ct_mri1</p> | <p>[Yes= 1; No= 2; Not sure/ Don't remember=3]</p> <p><input type="checkbox"/> str_ct_mri2</p> | <p>[Yes= 1; No= 2; Not sure/ Don't remember=3]</p> <p><input type="checkbox"/> str_ct_mri3</p> |
| <p>3.25 If not hospitalized, why?</p> <p>Visited allopathic doctor and took treatment as outpatient 1</p> <p>Visited Ayurveda/homeopathic /other traditional healers 2</p> <p>Others 3</p> <p>Not sure/ Don't remember 4</p> | <p><input type="checkbox"/> hosp_nt1</p> <p>If others please specify</p> <p><input type="text"/> hosp_nt_sp1</p> | <p><input type="checkbox"/> hosp_nt2</p> <p>If others please specify</p> <p><input type="text"/> hosp_nt_sp2</p> | <p><input type="checkbox"/> hosp_nt3</p> <p>If others please specify</p> <p><input type="text"/> hosp_nt_sp3</p> |

| | | | |
|--|---|--|--|
| <p>3.26 Ask the participant whether they have medical records related to the events and current medication & treatment. If so, please take pictures of every page of the record.</p> <p>A. Discharge reports</p> <p>B. Consultant notes</p> <p>C. Prescription notes</p> <p>D. ECG</p> <p>E. CT scan reports</p> <p>F. MRI reports</p> <p>G. Lab reports</p> <p>H. Other</p> | <p>[Yes=1; No=2]</p> <div> <input type="checkbox"/> str_rec_disrepo1 </div> <div> <input type="checkbox"/> str_rec_conote1 </div> <div> <input type="checkbox"/> str_rec_pres1 </div> <div> <input type="checkbox"/> str_rec_ecg1 </div> <div> <input type="checkbox"/> str_rec_ct1 </div> <div> <input type="checkbox"/> str_rec_mri1 </div> <div> <input type="checkbox"/> str_rec_ot1 </div> <p>If others please specify</p> <div> <input type="text"/> str_rec_otsp1 </div> | <p>[Yes=1; No=2]</p> <div> <input type="checkbox"/> str_rec_disrepo2 </div> <div> <input type="checkbox"/> str_rec_conote2 </div> <div> <input type="checkbox"/> str_rec_pres2 </div> <div> <input type="checkbox"/> str_rec_ecg2 </div> <div> <input type="checkbox"/> str_rec_ct2 </div> <div> <input type="checkbox"/> str_rec_mri2 </div> <div> <input type="checkbox"/> str_rec_lab2 </div> <div> <input type="checkbox"/> str_rec_ot2 </div> <p>If others please specify</p> <div> <input type="text"/> str_rec_otsp2 </div> | <p>[Yes=1; No=2]</p> <div> <input type="checkbox"/> str_rec_disrepo3 </div> <div> <input type="checkbox"/> str_rec_conote3 </div> <div> <input type="checkbox"/> str_rec_pres3 </div> <div> <input type="checkbox"/> str_rec_ecg3 </div> <div> <input type="checkbox"/> str_rec_ct3 </div> <div> <input type="checkbox"/> str_rec_mri3 </div> <div> <input type="checkbox"/> str_rec_lab3 </div> <div> <input type="checkbox"/> str_rec_ot3 </div> <p>If others please specify</p> <div> <input type="text"/> str_rec_otsp3 </div> |
| <p>3.27 Do you have a residual disability in any part of the body?</p> | <p>Yes 1</p> <p>No 2</p> | <div> <input type="checkbox"/> disab_body </div> <p>If "2" skip to Q.3.29</p> | |
| <p>3.28 If 'YES', does it involve the following?</p> <p>[Yes=1; No=2]</p> | <p>A. Paralysis of leg/foot</p> <p>B. Paralysis of arm/hand</p> <p>C. Weakness of leg/foot</p> <p>D. Weakness of arm/hand</p> <p>E. Defect of speech</p> <p>F. Defect of vision</p> <p>G. Urinary incontinence</p> <p>H. Any other weakness</p> | <div> <input type="checkbox"/> para_leg </div> <div> <input type="checkbox"/> para_arm </div> <div> <input type="checkbox"/> weak_leg </div> <div> <input type="checkbox"/> weak_arm </div> <div> <input type="checkbox"/> defect_speech </div> <div> <input type="checkbox"/> defect_vision </div> <div> <input type="checkbox"/> urin_incon </div> <div> <input type="checkbox"/> other_weak </div> <p>If other, please specify</p> <div> <input type="text"/> other_weak_sp </div> | |
| <p>3.29 Are you advised to continue any medication after your paralytic attack?</p> | <p>Yes 1</p> <p>No 2</p> | <div> <input type="checkbox"/> adv_medicine </div> | |

| | | | |
|--|---|---|---|
| 3A-IIIA : Stroke free status (All stroke free participants) {Fill only if the answer to Q3.17 is 2 or 3}. Questionnaire for Verifying Stroke-Free Status (QVSFS – Jones et al) | | | |
| Codes: Yes=1 No=2 Not sure/Don't know=3 | | | |
| 3.30 Were you ever told by a physician that you had a TIA, ministroke, or transient ischemic attack? | <input type="checkbox"/> tia_mini_ischemic | | |
| 3.31 Have you ever had sudden painless weakness on one side of your body? | <input type="checkbox"/> pless_wak_oneside | | |
| 3.32 Have you ever had sudden numbness or a dead feeling on one side of your body? | <input type="checkbox"/> dead_fel_oneside | | |
| 3.33 Have you ever had sudden painless loss of vision in one or both eyes? | <input type="checkbox"/> loss_vision | | |
| 3.34 Have you ever suddenly lost one half of your vision? | <input type="checkbox"/> lost_onhalf_vision | | |
| 3.35 Have you ever suddenly lost the ability to understand what people are saying? | <input type="checkbox"/> lost_abli_ustand | | |
| 3.36 Have you ever suddenly lost the ability to express yourself verbally or in writing? | <input type="checkbox"/> lost_abli_exp | | |
| 3A-IV: KIDNEY | | | |
| 3.37 Have you EVER been told by a doctor that you have: | A. Kidney stone kd_st B. Kidney disease kd_dis C. Kidney failure kd_fail | Yes=1; No=2 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | If YES, since how long? (For kidney stones: most recent) <div style="display: flex; justify-content: space-around;"> <div style="text-align: center;"> YY <input type="text"/> <input type="text"/> kd_sty </div> <div style="text-align: center;"> MM <input type="text"/> <input type="text"/> kd_stmo </div> </div> <div style="display: flex; justify-content: space-around;"> <div style="text-align: center;"> <input type="text"/> <input type="text"/> kd_disy </div> <div style="text-align: center;"> <input type="text"/> <input type="text"/> kd_dismo </div> </div> <div style="display: flex; justify-content: space-around;"> <div style="text-align: center;"> <input type="text"/> <input type="text"/> kd_faily </div> <div style="text-align: center;"> <input type="text"/> <input type="text"/> kd_failmo </div> </div> |
| If all the options in Q.3.37 is filled with "2" skip to "3A-V" | | | |
| 3.38 If YES for kidney stones, what treatment was received? | Only medication 1 Surgery 2 No treatment 3 Others 4 | <div style="text-align: right;"> <input type="checkbox"/> kd_st_trt </div> If others (Option 4), then specify kd_st_trtsp _____ | |
| 3.39 If YES , for kidney disease or kidney failure <div style="text-align: center;">[Yes =1; No =2]</div> | A. Have you ever undergone dialysis? B. Have you ever undergone kidney transplant? | | <div style="text-align: right;"> <input type="checkbox"/> kd_dial <input type="checkbox"/> kd_trp </div> |
| 3A-V: CANCER | | | |
| 3.40 Have you EVER been told by a doctor that you have cancer? <div style="text-align: center;">[Yes=1 ; No=2; Don't know=3]</div> | <div style="text-align: right;"> <input type="checkbox"/> ever_can </div> If "2" or "3" skip to "PART 3A-VA" | | |

| | | | |
|---|--|--|--|
| <p>3.41A If yes, which site</p> <p>a. Site 1 <input type="text"/> can_site1</p> <p>b. Site 2 <input type="text"/> can_site2</p> <p>c. Site 3 <input type="text"/> can_site3</p> <p>d. Site 4 <input type="text"/> can_site4</p> <p>e. Site 5 <input type="text"/> can_site5</p> <p>If "14", then specify _____ can_site_sp</p> | <p>3.41B How was it detected?</p> <p><input type="text"/> can_dted1</p> <p><input type="text"/> can_dted2</p> <p><input type="text"/> can_dted3</p> <p><input type="text"/> can_dted4</p> <p><input type="text"/> can_dted5</p> | <p>3.41C At what stage it was diagnosed?</p> <p><input type="text"/> can_stg1</p> <p><input type="text"/> can_stg2</p> <p><input type="text"/> can_stg3</p> <p><input type="text"/> can_stg4</p> <p><input type="text"/> can_stg5</p> | <p>3.41D When were you diagnosed with it? Year of diagnosis</p> <p><input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> can_diayr1</p> <p><input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> can_diayr2</p> <p><input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> can_diayr3</p> <p><input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> can_diayr4</p> <p><input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> can_diayr5</p> |
| <p>Codes</p> | | | |
| <p>Oral =1 ; Esophagus (Food pipe) =2 ; Stomach=3 ; Other pharynx= 4 ; Colo-rectum = 5; Larynx= 6; Liver =7 ; Lung = 8 ; Breast = 9; Cervix = 10; Ovary = 11; Prostate = 12 ; Gall bladder= 13; Others = 14; Unknown =15</p> | <p>Participant had symptoms=1 At routine checkup or screening=2 Not sure/Don't know=3</p> | <p>Stage0/in situ stage=1; Stage I= 2; Stage II=3; Stage III=4; Stage IV=5; Don't know=6</p> | |
| <p>3.42What was the primary treatment? [Yes=1; No=2]</p> | <p>A. Surgery</p> <p>B. Hormone therapy</p> <p>C. Radiology (X-ray for treatment)</p> <p>D. Chemotherapy (cancer cell killing drugs)</p> <p>E. Palliative treatment (treatment to relieve pain)</p> <p>F. Non-allopathic (Ayurvedic/ Homeopathic/ traditional)</p> <p>G. Others</p> <p>H. Don't know</p> | | <p><input type="text"/> can_sur</p> <p><input type="text"/> can_hothy</p> <p><input type="text"/> can_radio</p> <p><input type="text"/> can_chemo</p> <p><input type="text"/> can_pall_trt</p> <p><input type="text"/> can_non_allop</p> <p><input type="text"/> can_oth</p> <p><input type="text"/> can_dtknow</p> <p>If others is "1", then specify _____ can_oth_sp</p> |

| PART- 3A-VA: PERCEIVED CANCER STIGMA | | | | |
|--|--|---|--|--|
| Codes: Yes = 1; No = 2; Don't know = 3; Refused = 4 | | | | |
| 3.43 If someone in your community had cancer, would they tell the neighbors? | | | <input type="checkbox"/> | can_comm |
| 3.44 Do people in the community avoid talking or eating with a person having cancer? | | | <input type="checkbox"/> | can_avoid |
| 3.45 Are people in your community afraid that cancer can spread from person to person? | | | <input type="checkbox"/> | can_spread |
| 3.46 Do people in the community think that cancer is a curse or result of past sins? | | | <input type="checkbox"/> | can_past_sins |
| PART-3 B: FRACTURE | | | | |
| 3.47 Have you ever had a broken bone or fracture? | | Yes No | 1 2 | <input type="checkbox"/> ever_fra If "2" skip to "Q3.49" |
| 3.48 If yes | Which bone/part of your body was fractured (Yes=1, No=2) | Age at most recent fracture for that bone* | Was this due to fall from standing height (example, falling in bathroom, fall while walking) (Yes=1, No=2) | If no, what was the cause? |
| Hip | hipfra | hipfra_age | hipfra_std | hipfra_cau |
| Wrist | wristfra | wristfra_age | wristfra_std | wristfra_cau |
| Spine/Vertebra | spinfra | spinfra_age | spinfra_std | spinfra_cau |
| Others | othfra | Specify :- oth_sp | | |
| <i>* If they had multiple fracture note the age of most recent fracture</i> | | | | |
| 3.49 Has either of your parents or siblings had a fracture of the hip, wrist or spine? | | Yes No Don't know | 1 2 3 | parfra <input type="checkbox"/> |
| PART- 3C: COMPLICATIONS (For all participants) | | | | |
| 3C-I: – FOOT ULCERS AND AMPUTATION | | | | |
| 3.50 Have you EVER had a non-healing ulcer/sore in the foot that took more than 4 weeks to heal? | | Yes No | 1 2 | ever_ulcer <input type="checkbox"/> |
| 3.51 Do you walk around bare foot? | | Yes No | 1 2 | wa_bfot <input type="checkbox"/> |
| 3.52 Have you had an amputation of lower limb? | | Yes No | 1 2 | amp <input type="checkbox"/> If "2" go to "PART 3C-II" |
| 3.53 If 'YES', when was your most recent amputation? | | <div> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </div> <div> <input type="text"/> <input type="text"/> </div> <div> Year amp_yr Month amp_mon </div> | | |

| | | |
|--|--|--|
| 3.54 On which lower limb (right, left or both) was the amputation? | Right 1 Left 2 Both 3 | <input type="checkbox"/> low_limb |
| 3.55 What was the level of amputation? (If both legs had amputation, please note the highest level) | Toe 1 Below ankle 2 Below knee 3 Above Knee 4 | <input type="checkbox"/> level_amp |
| 3.56 What was the cause for the most recent amputation? | Injury 1 Diabetes 2 Infection 3 Diabetes and Injury 4 Diabetes and infection 5 Others 6 | <input type="checkbox"/> cause_amp If Others (option 6), then specify cause_amp_sp ----- |
| 3.57 Do you have medical records or prescriptions from the ulcer diagnosis or amputation? | Yes 1 No 2 Don't Know 3 | <input type="checkbox"/> amp_rec |
| 3.58 Ask the participant whether they have medical records related to the events. If so, please take pictures of every page of the record. ampdirec | | |
| 3C-II: – EYES | | |
| 3.59 Have you ever seen a doctor for difficulty with your eyesight other than your ordinary power glasses (spectacles)? | Yes 1 No 2 | <input type="checkbox"/> eyedif If “ 2” go to “Section 4” |
| 3.60 If “Yes”, did the doctor ever tell you that you have: | Cataract 1 Retinopathy 2 Both 3 Other 4 | <input type="checkbox"/> dr_tell If Others (option 4), then specify dr_tell_sp ----- |
| 3.61 If 2 or 3 for Q3.60, when was the retinopathy diagnosed? | <div> <input type="text"/> <input type="text"/> Year Month ret_dia_yr ret_dia_mon </div> | |
| 3.62 Have you undergone laser therapy (Photocoagulation) anytime? | Yes 1 No 2 | <input type="checkbox"/> lase_thp If “2” skip to Q3.64 |
| 3.63 If “Yes” for Q3.62, when? | <div> <input type="text"/> <input type="text"/> <input type="text"/> Year Month lase_thp_mo </div> | |
| 3.64 Do you have medical records or prescriptions? | Yes 1 No 2 | <input type="checkbox"/> eye_rec |
| 3.65 Ask the participant whether they have medical records related to the events. If so, please take pictures of every page of the record. eyedirec | | |

| Section:-4 DRUG INFORMATION | | |
|---|---|--|
| 4.1 In the past one week, have you taken any Allopathic drug (English / modern) for a disease? [Yes= 1; No =2] | | <input type="checkbox"/> take_drug If “2” go to “Section 5” |
| 4.2 If yes, provide details of all the medication that the participant is taking in the PAST WEEK of survey in the below columns | | |
| Name of the drug (Write in CAPTIAL letters) | | |
| a. | drug_name1 | |
| b. | drug_name2 | |
| c. | drug_name3 | |
| d. | drug_name4 | |
| e. | drug_name5 | |
| f. | drug_name6 | |
| g. | drug_name7 | |
| h. | drug_name8 | |
| i. | drug_name9 | |
| j. | drug_name10 | |
| Section-5: PATIENT HEALTH QUESTIONNAIRE -9 (PHQ-9) | | |
| S.No | Over the last 2 weeks, how often have you been bothered by any of the following problems (1-10) | 1. Not at All 2. Several Days 3. More than half the time 4. Nearly every day |
| A. | Have little interest or pleasure in doing things | <input type="checkbox"/> phq_1 |
| B. | Feeling down, depressed, or hope less | <input type="checkbox"/> phq_2 |
| C. | Trouble falling or staying asleep or sleeping too much | <input type="checkbox"/> phq_3 |
| D. | Feel tired or feel like having little energy | <input type="checkbox"/> phq_4 |
| E. | Poor appetite or overeat | <input type="checkbox"/> phq_5 |
| F. | Feeling bad about yourself – or that you are a failure or have let yourself or your family down | <input type="checkbox"/> phq_6 |
| G. | Trouble concentrating on things, such as reading the newspaper or watching television | <input type="checkbox"/> phq_7 |
| H. | Moving or speaking so slowly that other people could have noticed Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual | <input type="checkbox"/> phq_8 |
| I. | Thoughts that you be better off dead, or of hurting yourself in some way | <input type="checkbox"/> phq_9 |
| J. | If you have checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people | <input type="checkbox"/> phq_10 1. Not difficult at all 2. Somewhat difficult 3. Very difficult 4. Extremely difficult |

| SECTION-6: QUALITY OF LIFE | | | |
|---|--|---|----------------------------------|
| Under each heading, please mention the number that describes your health today | | | |
| A. Mobility | I have no problems in walking about | 1 | <input type="checkbox"/> qolmob |
| | I have slight problems in walking about | 2 | |
| | I have moderate problems in walking about | 3 | |
| | I have severe problems in walking about | 4 | |
| | I am unable to walk about | 5 | |
| B. Self- Care | I have no problems in bathing or dressing myself | 1 | <input type="checkbox"/> qolself |
| | I have slight problems in bathing or dressing myself | 2 | |
| | I have moderate problems in bathing or dressing myself | 3 | |
| | I have severe problems in bathing or dressing myself | 4 | |
| | I am unable to bath or dress myself | 5 | |
| C. Usual Activities (e.g., work, study housework family or leisure activities) | I have no problems doing my usual activities | 1 | <input type="checkbox"/> qoluaat |
| | I have slight problems doing my usual activities | 2 | |
| | I have moderate problems doing my usual activities | 3 | |
| | I have severe problems doing my usual activities | 4 | |
| | I am unable to do my usual activities | 5 | |
| D. Pain/ Discomfort | I have no pain or discomfort | 1 | <input type="checkbox"/> qolpain |
| | I have slight pain or discomfort | 2 | |
| | I have moderate pain or discomfort | 3 | |
| | I have severe pain or discomfort | 4 | |
| | I have extreme pain or discomfort | 5 | |
| E. Anxiety/ Depression | I am not anxious or depressed | 1 | <input type="checkbox"/> qolands |
| | I am slightly anxious or depressed | 2 | |
| | I am moderately anxious or depressed | 3 | |
| | I am severely anxious or depressed | 4 | |
| | I am extremely anxious or depressed | 5 | |

F.

- We would like to know how good or bad your health is TODAY.
- This scale is numbered from 0 to 100.
- 100 means the **best** health you can imagine.

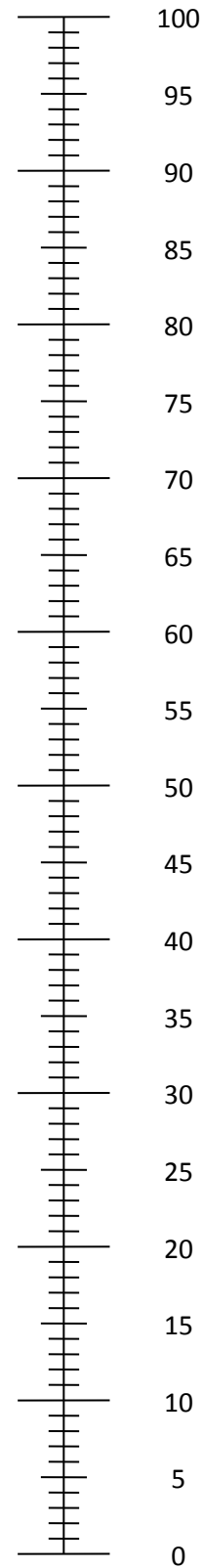
“0” means the **worst** health you can imagine.

- Mark an X on the scale to indicate how your health is TODAY.
- Now, please write the number you marked on the scale in the box below.

YOUR HEALTH TODAY=

qolhstus

The best health
you can imagine



The worst health
you can imagine

| SECTION 7: FEMALE REPRODUCTIVE HISTORY (Only for Female) | | |
|--|--|---|
| PART- 7A: THIS SECTION TO BE FILLED ONLY FOR THE FEMALE PARTICIPANTS. FOR MALE PARTICIPANTS SKIP THIS SECTION AND THANK THE PARTICIPANT | | |
| 7.1 Are you currently having menstrual cycles? | Yes 1 No 2 | <input type="checkbox"/> frh_hmens If "1" go to Q.7.4 |
| 7.2 If 'No' what is the reason? | Pregnancy 1 Lactation 2 Natural menopause 3 Surgical menopause 4 Others 5 | <input type="checkbox"/> frh_res If others (option 5), then specify frh_res_sp |
| 7.3 If menopausal, since how long? [Ask if Q.7.2 is filled with option 3 or 4] | <div> <input type="text"/> <input type="text"/> YY frh_menp_yr <input type="text"/> <input type="text"/> MM frh_menp_mon </div> | |
| 7.4 When was your last menstrual period (LMP)? If the participant is able to recall skip to Q7.5 otherwise fill Q7.4a | <div> <input type="text"/> <input type="text"/> D <input type="text"/> <input type="text"/> M <input type="text"/> <input type="text"/> Y <input type="text"/> <input type="text"/> Y </div> frh_imp | |
| 7.4a If the participant cannot recall the date of her LMP frh_nrcal_yr | <div> <input type="text"/> <input type="text"/> Y <input type="text"/> <input type="text"/> M <input type="text"/> <input type="text"/> M <input type="text"/> <input type="text"/> D <input type="text"/> <input type="text"/> D </div> frh_nrcal_mo frh_nrcal_dy Ago | |
| 7.5 Are you currently using hormonal drugs or oral contraceptive pills? [Yes= 1, No=2] | <input type="checkbox"/> frh_hmo_drg | |
| 7.6 Number of pregnancies so far? [also include miscarriages/abortions] | <input type="text"/> <input type="text"/> frh_preg If 00, skip to Q7.11 | |
| 7.7 In the last pregnancy was the delivery : | Normal 1 Caesarian Section 2 Others 3 Not applicable 9 | <input type="checkbox"/> frh_last_del If others (option 3), then specify frh_last_del_sp |
| 7.8 Were you diagnosed to have gestational diabetes in any of the pregnancies? | Yes 1 No 2 Don't know 3 Not applicable 9 | <input type="checkbox"/> frh_gesdiab |
| 7.9 Were you diagnosed to have hypertension in any of the pregnancies? | Yes 1 No 2 Don't know 3 Not applicable 9 | <input type="checkbox"/> frh_diahbp |
| 7.10 What is the date of birth of your youngest biological child? If the participant is able to recall skip to Q7.11 otherwise fill Q7.10a | <div> <input type="text"/> <input type="text"/> D <input type="text"/> <input type="text"/> M <input type="text"/> <input type="text"/> Y <input type="text"/> <input type="text"/> Y </div> feh_bod_child | |
| 7.10a What is the age of your youngest biological child? | <div> <input type="text"/> <input type="text"/> YY age_child_yr <input type="text"/> <input type="text"/> MM age_child_mo </div> | |

| PART- 7B: CANCER SCREENING | | |
|--|--|--|
| <p>7.11 Have you ever had the following exams done by a physician, nurse or other health professional?</p> <p>A. Breast examination</p> <p>B. Mammogram (A mammogram is an X-ray image of your breast used to screen for breast cancer)</p> | <p>[Yes= 1; No= 2; Don't know/ Not sure= 3]</p> <div> <input type="checkbox"/> <small>exm_bre</small> <input type="checkbox"/> <small>exm_mammo</small> </div> <p>If "2" or "3" skip to Q7.15</p> | |
| <p>7.12 If yes for "Q7.11" when was the last time you had?</p> <p><1 year ago 1</p> <p>1-5 years ago 2</p> <p>>5 years ago 3</p> | <p>Breast examination</p> <input type="checkbox"/> <small>lst_tmebre</small> | <p>Mammogram</p> <input type="checkbox"/> <small>lst_tmrmom</small> |
| <p>7.13 Do you know why the breast exam was done?</p> <p>[Yes=1; No=2]</p> | | <input type="checkbox"/> <small>why_brexm</small> <p>If "2" skip to Q7.15</p> |
| <p>7.14 If yes, why was this examination done?</p> <p>[Yes=1; No=2; Not sure/Don't know=3]</p> | <p>A. General health check-up</p> <p>B. Doctor suggested to do the exam because of my age or family history of breast cancer</p> <p>C. I was having discomfort, pain or symptoms</p> <p>D. Others</p> | <div> <input type="checkbox"/> <small>exm_gchk</small> <input type="checkbox"/> <small>exm_fam_his</small> <input type="checkbox"/> <small>exm_sym</small> <input type="checkbox"/> <small>exm_ot</small> </div> <p>If others, please specify</p> <p><small>exm_otsp</small> _____</p> |

| | | |
|---|---|--|
| <p>7.15 Have you ever had the following exams for cervical cancer done by a physician, nurse or other health professional?</p> <div style="border: 1px solid black; padding: 5px; margin: 5px 0;"> <p>A. Pap smear (Cervix is the mouth of the uterus. Cervical cancer can be detected even before there are symptoms by several tests. In pap-smear a doctor takes a sample of cells from the cervix)</p> </div> <div style="border: 1px solid black; padding: 5px; margin: 5px 0;"> <p>B. Visual exam with acetic acid (Cervix is the mouth of the uterus. Cervical cancer can be detected even before there are symptoms by several tests. In this test the doctor look at the mouth of the uterus, paint some vinegar on it, and see if there are any changes that look like cancer)</p> </div> | <p>[Yes= 1; No= 2; Don't know/ Not sure= 3]</p> <div style="margin-top: 20px;"> <input type="checkbox"/> exm_papsm </div> <div style="margin-top: 20px;"> <input type="checkbox"/> exm_vis </div> <p style="margin-top: 20px;">If "2" or "3" thank the participant and end the questionnaire</p> | |
| <p>7.16 If yes for "Q7.15" when was the last time you had?</p> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <1 year ago 1 </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> 1-5 years ago 2 </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> >5 years ago 3 </div> | <p>Pap smear</p> <div style="margin-top: 10px;"> <input type="checkbox"/> lst_papsm </div> | <p>Visual exam with acetic acid</p> <div style="margin-top: 10px;"> <input type="checkbox"/> lst_vis </div> |
| <p>7.17 Do you know why these exam done?</p> <p style="margin-top: 10px;">[Yes=1; No=2]</p> | <div style="text-align: right; margin-bottom: 10px;"> <input type="checkbox"/> why_exdo </div> <p>If "2" thank the participant and end the questionnaire</p> | |
| <p>7.18 If yes for Q7.17</p> <div style="margin-top: 10px;"> <p>A. General health check-up</p> <p>B. Doctor suggested to do the exam because of my age or family history of breast cancer</p> <p>C. I was having discomfort, pain or symptoms</p> <p>D. Others</p> </div> | <p>[Yes=1; No=2]</p> <div style="margin-top: 10px;"> <input type="checkbox"/> exdo_gchk </div> <div style="margin-top: 10px;"> <input type="checkbox"/> exdo_fam_his </div> <div style="margin-top: 10px;"> <input type="checkbox"/> exdo_sym </div> <div style="margin-top: 10px;"> <input type="checkbox"/> exdo_ot </div> | <p>If yes for others please specify</p> <div style="margin-top: 10px;"> <input type="text"/> exdo_otsp </div> |

End time

Hours : Minutes

FOR QUALITY CHECK

| | | |
|---|---|--|
| <p style="text-align: center;">REVIEWER 1</p> <p>NAME: _____</p> <p>SIGNATURE: _____</p> <p>DATE: ____/____/____</p> | <p style="text-align: center;">REVIEWER 2</p> <p>NAME: _____</p> <p>SIGNATURE: _____</p> <p>DATE: ____/____/____</p> | <p style="text-align: center;">DATA ENTRY/SCANNING</p> <p>NAME: _____</p> <p>SIGNATURE: _____</p> <p>DATE: ____/____/____</p> |
|---|---|--|

