**CARRS GEOHEALTH**

**FORM-1**

**Cohort2: 1st follow up questionnaire- Part I**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Household ID: - hh\_id | | | | | Follow up ID: -  fup\_id | | | | | | | Interviewer ID: - iid | | | |
| Participant ID :- pid | | | | | Date of Interview :- doi | | | | | | | Time of Interview:-  str\_time | | | |
| GPS Reading :- gps\_reading | | | | |  | | | | | | | | | | |
| **Part-1 : Response and contact of the participant** | | | | | | | | | | | | | | | |
| Does the participant agree to be interviewed? agr\_int | | | | | 1=Yes 2=No | | | | | | |  | | | |
| If Agreed to interview:- | | | | | | | | | | | | | | | |
| First Name of the participant :- par\_first\_name | | | | |  | | | | | | | | | | |
| Middle Name of the participant:- par\_mid\_name | | | | |  | | | | | | | | | | |
| Last Name of the participant:- par\_last\_name | | | | |  | | | | | | | | | | |
| First name of the participant Father:- fat\_first\_name | | | | |  | | | | | | | | | | |
| Middle name of the participant Father:- fat\_mid\_name | | | | |  | | | | | | | | | | |
| Last name of the participant Father:- fat\_last\_name | | | | |  | | | | | | | | | | |
| First name of the participant Mother:- moth\_first\_name | | | | |  | | | | | | | | | | |
| Middle name of the participant Mother:- moth\_mid\_name | | | | |  | | | | | | | | | | |
| Last name of the participant Mother:- moth\_last\_name | | | | |  | | | | | | | | | | |
| Sex:- sex | | | | | 1=Male 2=Female | | | | | | |  | | | |
| What is your marital status ? mat\_sts | | | | | 1=Single 2=Married 3=Widow/Widower 4=Separated/Divorced 5=Others | | | | | | | If other please specify mat\_sts\_sp \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| If married :- | | | | | | | | | | | | | | | |
| First name of the spouse:- | | | | | spou\_first\_name | | | | | | | | | | |
| Middle name of the spouse:- | | | | | spou\_mid\_name | | | | | | | | | | |
| Last name of the spouse:- | | | | | spou\_last\_name | | | | | | | | | | |
| For men, relationship with the female participant (ask only for male participant)  relation | | | | | 1=Husband 2=Father-in-law 3=Son 4=Father 5=Grand father 6=Brother-in-law (husband’s brother) 7=Brother-in-law (sister’s husband) 8=Son-in-law 9=Brother 10=Cousin 11=No female participant is selected 12=Female participant was adopted into the family 13=Male participant was adopted into the family 14=Others | | | | | | | If other specify  relation\_sp  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| what is the present address agr\_yes | | | | | 1=Same as baseline survey  2=Changed | | | | | | |  | | | |
| If changed, note the current address:- add\_chg | | | | |  | | | | | | | | | | |
| Please write down participant mobile number :- 1 ph1 | | | | |  | | | | | | | | | | |
| Please write down participant mobile number :- 2 ph2 | | | | |  | | | | | | | | | | |
| If NO, what is the reason for non-response? agr\_no | | | | | 1= Shifted not traceable 2= Shifted, traceable but not interested 3= Shifted but not approachable/out of area range 4= Hard refusal 5= Soft refusal 6= Deceased 7= Could not complete this survey and will available for next year follow-up 8= Others | | | | | | | If other specify agr\_no\_sp \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| If “Refused”, reasons for refusal | | | | | refuse\_reason | | | | | | | | | | |
| Part 1A:- Details of contacts:- | | | | | | | | | | | | | | | |
| Name of the 1st contact :- | | | | | cont\_name\_1 | | | | | | | | | | |
| Address of 1st contact :- | | | | | cont\_add\_1 | | | | | | | | | | |
| Telephone number of 1st contact :- | | | | | cont\_ph\_1 | | | | | | | | | | |
| Name of the 2nd contact :- | | | | | cont\_name\_2 | | | | | | | | | | |
| Address of 2nd contact :- | | | | | cont\_add\_2 | | | | | | | | | | |
| Telephone number of 2nd contact :- | | | | |  | | | | | | | | | | |
| Name of the Home Town contact :- | | | | | cont\_name\_ht | | | | | | | | | | |
| Address of Home Town contact :- | | | | | cont\_add\_ht | | | | | | | | | | |
| Telephone number of Home Town contact:- | | | | | cont\_ph\_ht | | | | | | | | | | |
| SECTION 1:- DURATION OF STAY IN CITY | | | | | | | | | | | | | | | |
| How long have you lived in the current city? live\_city  (If participant responds since birth, please enter the current age of the participant) | | | | |  | | | | | | | | | | |
| How long have you lived in your current home?  (If participant responds since birth, please enter the current age of the participant in years | | | | | cur\_home\_yr cur\_home\_mo   YEAR MONTH | | | | | | | | | | |
| Does the participant has adhaar card? addh | | | | | 1=Yes 2=No | | | | | |  | | | | |
| If yes, please write the adhaar card number addh\_yes | | | | |  | | | | | | | | | | |
| SECTION 2: OCCUPATION DETAILS | | | | | | | | | | | | | | | |
| Are you employed/studying currently? emp\_stdy | | | | | 1=Yes 2=No 3=Refused | | | | | | |  | | | |
| Are you student? student | | | | | 1=Yes 2=No | | | | | | |  | | | |
| If employed :- | | | | | | | | | | | | | | | |
| What is your primary occupation (work)? prim\_work | | | | | 1=Professional, big business owner, landlord (>10acre), university teacher, class1 IAS/services officer, lawyer, office workers/health professionals, banker)  2=Trained, clerical, medium business owner, middle level farmer (2-10 acre), teacher, maintenance (in charge), personnel manager  3=Skilled manual labourer, small business owner, small farmer (<1 acre); plant and machine operators and assembler Industrial site metal/glass/ceramics/wood/paper/chemical processing  4=Semi-skilled manual labourer: marginal landowner, rickshaw /auto/bus driver, army jawan, domestic helper/ waitress/ cook/ security); carpenter, fitter, car mechanic/printer/metal worker or welder / potters/ glassmaker/ woodwork/leather) 5=Unskilled manual Laborer (construction worker/manual labor/garbage collectors), landless laborer | | | | | | | Specify the occupation prim\_work\_sp  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| How long have you been working in this field? | | | | | work\_yr work\_mo  YEAR MONTH | | | | | | | | | | |
| Do you have any secondary occupation? sec\_wrk | | | | | 1=Yes 2=No | | | | | | |  | | | |
| If 'Yes" what is your secondary occupation (work)  sec\_wrk\_occ | | | | | 1=Professional, big business owner, landlord (>10acre), university teacher, class1 IAS/services officer, lawyer, office workers/health professionals, banker)  2=Trained, clerical, medium business owner, middle level farmer (2-10 acre), teacher, maintenance (in charge), personnel manager  3=Skilled manual labourer, small business owner, small farmer (<1 acre); plant and machine operators and assembler Industrial site metal/glass/ceramics/wood/paper/chemical processing  4=Semi-skilled manual labourer: marginal landowner, rickshaw /auto/bus driver, army jawan, domestic helper/ waitress/ cook/ security); carpenter, fitter, car mechanic/printer/metal worker or welder / potters/ glassmaker/ woodwork/leather) 5=Unskilled manual Laborer (construction worker/manual labor/garbage collectors), landless laborer | | | | | | | Specify the occupation sec\_wrk\_occ\_sp \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| How long have you been working in this field? | | | | | sec\_wrk\_yr sec\_wrk\_mo  YEAR MONTH | | | | | | | | | | |
| Does the participant agreed to provide his/her work/study address? pro\_wrk\_add | | | | | 1=Yes 2=No | | | | | | |  | | | |
| If Yes Address of work/study | | | | | | | | | | | | | | | |
| Number, street name:- add\_wrk\_strt | | | | |  | | | | | | | | | | |
| Locality/Landmark:- add\_wrk\_loc | | | | |  | | | | | | | | | | |
| City:- add\_wrk\_city | | | | |  | | | | | | | | | | |
| State:- add\_wrk\_state | | | | |  | | | | | | | | | | |
| Pincode:- add\_wrk\_pin | | | | |  | | | | | | | | | | |
| At your place of employment/study is it  wrk\_place | | | | | 1= Outdoors 2=Indoors with a lot of outdoor air exposure 3=Indoors with some/mixed outdoor air exposure 4=Indoors with very little outdoor air exposure (closed doors and windows all the time | | | | | | |  | | | |
| How many working days do you have in a week? wrk\_dy | | | | | | | | | | | |  | | | |
| What is the average number of hours per day you are at your place of employment/ study? | | | | | wrk\_avg\_hr wrk\_avg\_min  HOURS MINUTES | | | | | | | | | | |
| How many nightshifts\* do you have in a month? (during last month)  (\*Nightshift work is defined as working during a non-standard shift schedule –outside 08:00AM to 8:00PM work day) night\_shift | | | | | | | | | | | |  | | | |
| **SECTION 3 :-TIME ACTIVITY** | | | | | | | | | | | | | | | |
| **3.1 On a typical WEEKDAY, please let us know how you spend your day?** | | | | | | | | | | | | | | | |
| **Hours** | | **Activity** | | | **Time spent outside (min)** | | | **Location** | | | | **Passive Smoking Exposure** | | | |
| 5-7 AM | | **wkdy\_5\_7am  wkdy\_5\_7am\_sp** | | | **wkdy\_5\_7am\_tso** | | | **wkdy\_5\_7am\_loc** | | | | **wkdy\_5\_7am\_psmk** | | | |
| 7-9 AM | | **wkdy\_7\_9am  wkdy\_7\_9am\_sp** | | | **wkdy\_7\_9am\_tso** | | | **wkdy\_7\_9am\_loc** | | | | **wkdy\_7\_9am\_psmk** | | | |
| 9-11 AM | | **wkdy\_9\_11am  wkdy\_9\_11am\_sp** | | | **wkdy\_9\_11am\_tso** | | | **wkdy\_9\_11am\_loc** | | | | **wkdy\_9\_11am\_psmk** | | | |
| 11-1PM | | **wkdy\_11\_1am  wkdy\_11\_1am\_sp** | | | **wkdy\_11\_1am\_tso** | | | **wkdy\_11\_1am\_loc** | | | | **wkdy\_11\_1am\_psmk** | | | |
| 1-3 PM | | **wkdy\_11\_1pm  wkdy\_11\_1pm\_sp** | | | **wkdy\_1\_3pm\_tso** | | | **wkdy\_1\_3pm\_loc** | | | | **wkdy\_1\_3pm\_psmk** | | | |
| 3-5 PM | | **wkdy\_3\_5pm  wkdy\_3\_5pm\_sp** | | | **wkdy\_3\_5pm\_tso** | | | **wkdy\_3\_5pm\_loc** | | | | **wkdy\_3\_5pm\_psmk** | | | |
| 5-7 PM | | **wkdy\_5\_7pm  wkdy\_5\_7pm\_sp** | | | **wkdy\_5\_7pm\_tso** | | | **wkdy\_5\_7pm\_loc** | | | | **wkdy\_5\_7pm\_psmk** | | | |
| 7-9 PM | | **wkdy\_7\_9pm  wkdy\_7\_9pm\_sp** | | | **wkdy\_7\_9pm\_tso** | | | **wkdy\_5\_7pm\_loc** | | | | **wkdy\_7\_9pm\_psmk** | | | |
| 9-11 PM | | **wkdy\_9\_11pm  wkdy\_9\_11pm\_sp** | | | **wkdy\_9\_11pm\_tso** | | | **wkdy\_5\_7pm\_loc** | | | | **wkdy\_9\_11pm\_psmk** | | | |
| 11-3AM | | **wkdy\_1\_3am  wkdy\_1\_3am\_sp** | | | **wkdy\_11\_3pm\_tso** | | | **wkdy\_5\_7pm\_loc** | | | | **wkdy\_11\_3am\_psmk** | | | |
| 3-5 AM | | **wkdy\_3\_5am  wkdy\_3\_5am\_sp** | | | **wkdy\_3\_5pm\_tso** | | | **wkdy\_5\_7pm\_loc** | | | | **wkdy\_3\_5am\_psmk** | | | |
| 3.2 On a typical **WEEKEND**, please let us know how you spend your day? | | | | | | | | | | | | | | | |
| **Hours** | | **Activity** | | | **Time spent outside (min)** | | | **Location** | | | | **Passive Smoking Exposure** | | | |
| 5-7 AM | | **wke\_5\_7am wke\_5\_7am\_sp** | | | **wke\_5\_7am\_tso** | | | **wke\_5\_7am\_loc** | | | | **wke\_5\_7am\_psmk** | | | |
| 7-9 AM | | **wke\_7\_9am wke\_7\_9am\_sp** | | | **wke\_7\_9am\_tso** | | | **wke\_7\_9am\_loc** | | | | **wke\_7\_9am\_psmk** | | | |
| 9-11 AM | | **wke\_9\_11am wke\_9\_11am\_sp** | | | **wke\_9\_11am\_tso** | | | **wke\_9\_11am\_loc** | | | | **wke\_9\_11am\_psmk** | | | |
| 11-1PM | | **wke\_11\_1pm wke\_11\_1pm\_sp** | | | **wke\_11\_1pm\_tso** | | | **wke\_11\_1pm\_loc** | | | | **wke\_11\_1pm\_psmk** | | | |
| 1-3 PM | | **wke\_1\_3pm wke\_1\_3pm\_sp** | | | **wke\_1\_3pm\_tso** | | | **wke\_1\_3pm\_loc** | | | | **wke\_1\_3pm\_psmk** | | | |
| 3-5 PM | | **wke\_3\_5pm wke\_3\_5pm\_sp** | | | **wke\_3\_5pm\_tso** | | | **wke\_3\_5pm\_loc** | | | | **wke\_3\_5pm\_psmk** | | | |
| 5-7 PM | | **wke\_5\_7pm wke\_5\_7pm\_sp** | | | **wke\_5\_7pm\_tso** | | | **wke\_5\_7pm\_loc** | | | | **wke\_5\_7pm\_psmk** | | | |
| 7-9 PM | | **wke\_7\_9pm wke\_7\_9pm\_sp** | | | **wke\_7\_9pm\_tso** | | | **wke\_7\_9pm\_loc** | | | | **wke\_7\_9pm\_psmk** | | | |
| 9-11 PM | | **wke\_9\_11pm wke\_9\_11pm\_sp** | | | **wke\_9\_11am\_tso** | | | **wke\_9\_11pm\_loc** | | | | **wke\_9\_11pm\_psmk** | | | |
| 11-3AM | | **wke\_11\_3am wke\_11\_3am\_sp** | | | **wke\_11\_3am\_tso** | | | **wke\_11\_3am\_loc** | | | | **wke\_11\_3pm\_psmk** | | | |
| 3-5 AM | | **wke\_3\_5am wke\_3\_5am\_sp** | | | **wke\_3\_5am\_tso** | | | **wke\_3\_5am\_loc** | | | | **wke\_3\_5am\_psmk** | | | |
| **Codes for Time activity (Question 3.1 & 3.2)** | | | | | | | | | | | | | | | |
| **Activity**   1. Sleeping /napping 2. Cooking/doing household chores 3. Shopping/ out-of-household work (meetings, socializing) 4. Occupation 5. Study 6. Travel/Commute: (Commute to work/drop to school/ commute to shopping) 7. Leisure/rest: (Watching TV/reading/chatting/visiting friends 8. Leisure time (includes recreational games, exercise)   9. Others If **other, then specify** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | **Location**   1. Indoor with closed windows 2. Indoor with open windows 3. Outdoor/ in an open vehicle (scooter/ bike/bicycle/rickshaw/auto) 4. Inside a closed vehicle (metro/bus/ car) | | | | | | | **Passive Smoking Exposure**   1. Yes 2. No 3. Don’t know/Not sure | | | |
| **SECTION:-4 BIOMASS AND KEROSENE USE** | | | | | | | | | | | | | | | |
| What is the type of cooking fuel commonly used in your home? | | | | | A. LPG fuel\_lpg | | | | | | | **Yes, primary=1; Yes, secondary=2**  **No, don’t use=3** | | | |
|  | | | |
| B. Electricity fuel\_elc | | | | | | |  | | | |
| C. kerosene fuel\_kro | | | | | | |  | | | |
| D. Biomass (Biomass –includes biomass pellets, wood, coconut shells, dried leaves/ dung cake) fuel\_bio | | | | | | |  | | | |
| E. Other, if other, then specify \_\_\_\_\_\_\_\_\_\_\_\_\_ fuel\_ot  fuel\_ot\_sp | | | | | | |  | | | |
| Do you use biomass or kerosene for other purposes other than cooking?  (Biomass –includes biomass pellets, wood, coconut shells, dried leaves/ dunk cake) | | | | | A. Lighting kero\_light | | | | | | | **Yes, primary=1; Yes, secondary=2**  **No, don’t use=3** | | | |
|  | | | |
| B. Heating kero\_heat | | | | | | |  | | | |
| C Boiling water kero\_bolwa | | | | | | |  | | | |
| D Other, if other, then specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_ kero\_ot  kero\_ot\_sp | | | | | | |  | | | |
| **SECTION 5:- TOBACCO AND ALCOHOL USE** | | | | | | | | | | | | | | | |
| Do you currently consume tobacco? con\_tob (currently refers to within last 1 year) | | | | 1=Yes 2=No | | | | | | | | |  | | |
| If yes, how often ? | | | | 1=Regularly (≥once a week) 2=Occasionally (less than one's a week) 3=No | | | | | **Smoking form**  con\_smok | | | | **Chew form** con\_chew | | **Any other form** con\_oth |
| Have you used alcoholic beverages in last  one year ? con\_alco | | | | 1=Yes 2=No 3=Don’t remember | | | | | | | | |  | | |
| If yes, how often did you consume? con\_alco\_often | | | | 1=Regularly (≥once a week) 2=Occasionally (less than one's a week) | | | | | | | | |  | | |
| **SECTION 6:- DIETARY INFORMATION** | | | | | | | | | | | | | | | |
| In a typical week, on how many days do you eat fruit? eat\_fruit | | | | | | | | | |  | | | | | |
| How many servings of fruit do you eat on one of those days?  eat\_fruit\_serv | | | | | | | | | |  | | | | | |
| In a typical week, on how many days do you eat vegetables? eat\_veg | | | | | | | | | |  | | | | | |
| How many servings of vegetables do you eat on one of those days? eat\_veg\_serv | | | | | | | | | |  | | | | | |
| **SECTION 7 A:- MEDICAL HISTORY (CARDIO METABOLIC DISEASES AND THEIR RISK FACTORS)** | | | | | | | | | | | | | | | |
| ***Part 7A: Fill this section if the answer for high blood pressure/ high blood sugar/high blood cholesterol is “YES” in PART section 7, Q.7.1.*** *If the answer is* ***‘YES’*** *to any of the choices in Q. 7.1, then go to Q.7.2.* ***‘OTHERWISE’*** *skip the entire part and go to Part 7B*  *\*Exclude pregnancy induced Hypertension and High Blood Sugar* | | | | | | | | | | | | | | | |
| **Part 7A-: HYPERTENSION (High Blood Pressure)/DIABETES (High Blood Sugar)/ HYPERLIPIDEMIA (High Blood Cholesterol)** | | | | | | | | | | | | | | | |
|  | | | **Hypertension**  **(High Blood Pressure) \*** | | | | | **Diabetes**  **(High Blood Sugar) \*** | | | | | **Dyslipidemia**  **(High Blood Cholesterol)** | | |
| 7.1 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 | | | | | diab | | | | | dys | | |
| **7.2 HOW OLD WERE** you when you were diagnosed **with** Hypertension/ Diabetes/ Hyperlipidemia? | | | **Completed age in Years**  Years  hbp\_age | | | | | **Completed age in Years**  Years  diab\_age | | | | | **Completed age in Years**  Years   dys\_age | | |
| 7.3 What treatment are you taking for it   currently? **[Yes=1; No=2]**   1. Prescribed dietary modification 2. Prescribed physical exercise 3. Yoga 4. Traditional medicine/Therapy\*\* other than yoga 5. Allopathic drugs(English/modern) | | | hbp\_diet  hbp\_excise  hbp\_yoga  hbp\_allop  hbp\_trade | | | | | diab\_diet  diab\_excise  diab\_yoga  diab\_allop  diab\_trade | | | | | dys\_diet  dys\_excise  dys\_yoga  dys\_allop  dys\_trade | | |
| **\*Traditional medicine/therapy include Ayurveda, Unani, Homeopathy, Tibetan, Naturopathy, Meditation** | | | | | | | | | | | | | | | |
| **SECTION 7 B:- HEART DISEASE** | | | | | | | | | | | | | | | |
|  | | |  | | | | | | | | | **[Yes=1; No=2; Don’t know/Not sure=3]** | | | |
| Have you EVER been told by a doctor that you have the following disease?  **If “2” or “3” for all options Q7.13** | | | 1. Heart Attack hrt\_atk 2. Angina angina 3. Heart Failure hrt\_fail 4. Valve disease val\_dis 5. Hole in the heart hole\_hrt 6. Not informed about the   nature of the problem not\_inform\_hrt 7. Other hrt\_ot hrt\_otsp   If other please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |  | | | |
| **If “1” for heart attack then fill the following questions otherwise skip to Q7.11** hrt\_atk\_yr hrt\_atk\_mo | | | | | | | | YEAR MONTH | | | | | | | |
| What symptoms did you have during this event? | | | | | 1- Chest pain/ discomfort >20 minutes  sys\_chst\_pain  2- Pain radiating to arm, shoulder or neck  sys\_chst\_radia  3- Sweating or vomiting  sys\_swt\_vomt  4—Other  sys\_ot  *“*If Other=1 then please specify” sys\_ot\_sp | | | | | | | Yes=1; No=2; Not sure=3 | | | |
|  | | | |
| How long these symptoms were present before you met doctor? | | | | | sys\_wk sys\_dy sys\_hr  Week Days Hours | | | | | | | | | | |
| Were you hospitalized for this event? hrt\_hosp | | | | | 1=Yes 2=No | | | | | | |  | | | |
| If hospitalized for this event, what procedure did the do in the hospital ? | | | | | Angioplasty (Stent) stent   Coronary Artery bypass surgery (Bypass) bypass  Thrombolytic therapy throm   Only medicines medicine   Other hosp\_ot   If other please specify hosp\_otsp  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | Yes=1; No=2 | | | |
| If not hospitalized for this event, where did you take treatment? | | | | | Visited allopathic doctor and took treatment as outpatient visit\_outpat  Visited Ayurveda/homeopathic/other traditional healers visit\_ayurved  Other visit\_ot   If other please specify visit\_otsp  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | Yes=1; No=2 | | | |
| 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 | | | | | Discharge reports rec\_dischg   Consultant notes rec\_consult   Prescription notes rec\_prescrip   ECG rec\_ecg   Lab Report rec\_labreport   Other rec\_ot   If other please specify  rec\_otsp | | | | | | | Yes=1; No=2 | | | |
| Are you taking any treatment for heart disease currently? | | | | | Allopathic drugs (English /modern) hrt\_trat\_alpath  Yoga hrt\_trat\_yoga   Traditional medicine (other than Yoga) hrt\_trat\_trdmed  Other hrt\_trat\_ot   If other please specify hrt\_trat\_otsp  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | Yes=1; No=2 | | | |
| 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 evr\_stent | | | | | 1=Yes  2=No | | | | | | |  | | | |
| If yes, when did you have latest procedure (date)? evr\_stent\_yr evr\_stent\_mo | | | | | YEAR MONTH | | | | | | | | | | |
| SECTION 7 C: STROKE (Paralytic attack) | | | | | | | | | | | | | | | |
| Have you EVER been told by a doctor that you have stroke (Paralytic attack)? | | | | | 1=Yes  2=No 3=Don’t know | | | | | | |  | | | |
| If yes, date of MOST RECENT of stroke (Paralytic attack). | | | | | YEAR MONTH | | | | | | | | | | |
| What symptoms did you experience? | | | | | Did you become unconscious or drowsy?   Was there loss of vision?   Was there weakness in face or limbs?)   Was there weakness in on limb/half of the body?   Was there difficulty in speaking?   Were there disturbances of balance or walking?   Was there trauma to the head or neck?   Was duration of any symptoms > 24 hours | | | | | | | Yes=1; No=2; Don’t remember/Not sure=3 | | | |
| Who diagnosed the stroke? | | | | | MBBS doctor   Ayurveda/homeopathic/traditional healer  Other   If other please specify  Not sure/ Don’t remember | | | | | | | Yes=1; No=2             \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Were you hospitalized for this stroke? | | | | | 1=Yes  2=No 3=Not sure/ Don’t remember | | | | | | |  | | | |
| If hospitalized for this stroke, was CT scan or MRI done? | | | | | 1=Yes  2=No 3=Not sure/ Don’t remember | | | | | | |  | | | |
| If not hospitalized, why? | | | | | 1=Visited allopathic doctor and took treatment as outpatient  2=Visited Ayurveda/homeopathic /other traditional healers  3=Others  If other please specify  4=Not sure/ Don’t remember | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| 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. | | | | | Discharge reports   Consultant notes   Prescription notes   ECG   CT scan reports   MRI Report   Lab report   Other  If other please specify | | | | | | | Yes=1 ;No=2  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Do you have a residual disability in any part of the body | | | | | 1=Yes  2=No | | | | | | |  | | | |
| If ‘YES’, does it involve the following? | | | | | Paralysis of leg/foot   Paralysis of arm/hand   Weakness of leg/foot   Weakness of arm/hand  Defect of speech   Defect of vision   Urinary incontinence   Any other weakness  If other please specify | | | | | | | Yes=1 ;No=2  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Are you advised to continue any medication after your paralytic attack? | | | | | 1=Yes  2=No | | | | | | |  | | | |
| Part 7D:- STROKE FREE STATUS (All stroke free participants) {Fill only if the answer to Q7.15 is 2 or 3}. | | | | | | | | | | | | | | | |
| Were you ever told by a physician that you had a TIA, ministroke, or transient ischemic attack? | | | | | 1=Yes  2=No 3=Not sure/Don’t know | | | | | | |  | | | |
| Have you ever had sudden painless weakness on one side of your body? | | | | | 1=Yes  2=No 3=Not sure/Don’t know | | | | | | |  | | | |
| Have you ever had sudden numbness or a dead feeling on one side of your body? | | | | | 1=Yes  2=No 3=Not sure/Don’t know | | | | | | |  | | | |
| Have you ever had sudden painless loss of vision in one or both eyes? | | | | | 1=Yes  2=No 3=Not sure/Don’t know | | | | | | |  | | | |
| Have you ever suddenly lost one half of your vision? | | | | | 1=Yes  2=No 3=Not sure/Don’t know | | | | | | |  | | | |
| Have you ever suddenly lost the ability to understand what people are saying? | | | | | 1=Yes  2=No 3=Not sure/Don’t know | | | | | | |  | | | |
| Have you ever suddenly lost the ability to express yourself verbally or in writing? | | | | | 1=Yes  2=No 3=Not sure/Don’t know | | | | | | |  | | | |
| Have you EVER been told by a doctor that you have cancer? | | | | | 1=Yes  2=No 3=Don’t know | | | | | | |  | | | |
|  | | **7.35A** **If yes, which site** | | | **7.35B How was it detected** | **7.35C At what stage it was diagnosed?** | | | | | | **7.35D When were you diagnosed   with it** | | | |
| A. Site 1 | |  | | |  |  | | | | | | **Year of diagnosis** | | | |
|  | | | |
| B. Site 2 | |  | | |  |  | | | | | |  | | | |
| C. Site 3 | |  | | |  |  | | | | | |  | | | |
| D. Site 4 | |  | | |  |  | | | | | |  | | | |
| E. Site 5 | | If other then specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |  |  | | | | | |  | | | |
| 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 | | | | | Participant had symptoms**=1**  At routine checkup or screening**=2**  Not sure/Don’t know**=3** | Stage0/in situ stage=**1**;  Stage I= **2**;  Stage II=**3**;  Stage III=**4**;  Stage IV=**5**;  Don’t know=**6** | | | | | |  | | | |
| What was the primary treatment? | | | | | Surgery   Hormone therapy   Radiology (X-ray for treatment)   Chemotherapy (cancer cell killing drugs)  Palliative treatment (treatment to relieve pain)   Non-allopathic (Ayurvedic/ Homeopathic/traditional)   Others  If other please specify  Don’t Know | | | | | | | Yes=1 ;No=2  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **Part- 7E-ii:- PERCEIVED CANCER STIGMA** | | | | | | | | | | | | | | | |
| **Codes: Yes = 1; No = 2; Don’t know = 3; Refused = 4** | | | | | | | | | | | | | | | |
| If someone in your community had cancer, would they tell the neighbors others (extended family, friends, neighbors) in the community? | | | | | | | | | | | |  | | | |
| Do people in the community avoid talking or eating with a person having cancer? | | | | | | | | | | | |  | | | |
| Are people in your community afraid that cancer can spread from person to person? | | | | | | | | | | | |  | | | |
| Do people in the community think that cancer is a curse or result of past sins? | | | | | | | | | | | |  | | | |
| **PART- 7F: COMPLICATIONS** (**For all participants)** | | | | | | | | | | | | | | | |
| ***7F-i:* – FOOT ULCERS AND AMPUTATION** | | | | | | | | | | | | | | | |
| Have you **EVER** had a non-healing ulcer/sore in the foot that took **more than 4 weeks** to heal | | | | | Yes 1  No 2 | | | | | | |  | | | |
| Do you walk around bare foot? | | | | | Yes 1  No 2 | | | | | | |  | | | |
| Have you had an amputation of lower limb? | | | | | Yes 1  No 2 | | | | | | |  | | | |
| If ‘**YES’,** when was your most recent amputation? | | | | | **Year Month** | | | | | | | | | | |
| On which lower limb (right, left or both) was the amputation? | | | | | Right 1  Left 2  Both 3 | | | | | | |  | | | |
| 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 | | | | | | |  | | | |
| 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 | | | | | | | **If Others (option 4), then specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |
| Do you have medical records or prescriptions from the ulcer diagnosis or amputation? If yes, please take pictures of every page of the record | | | | | Yes 1  No 2 Don’t Know 3 | | | | | | |  | | | |
| ***7F-ii:* – EYES** | | | | | | | | | | | | | | | |
| Have you ever seen a doctor for difficulty with your eyesight other than your ordinary power glasses (spectacles)? | | | | | Yes 1  No 2 | | | | | | |  | | | |
| If **“Yes”,** did the doctor ever tell you that you have: | | | | | Cataract 1 Retinopathy 2  Both 3 Other 4 | | | | | | | **If Others (option 4), then specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |
| If 2 or 3 for Q7.50, when was the retinopathy diagnosed? | | | | | Year Month | | | | | | | | | | |
| Have you undergone laser therapy (Photocoagulation) anytime? | | | | | Yes 1  No 2 | | | | | | |  | | | |
| If “Yes” for Q7.52, when? | | | | | Year Month | | | | | | | | | | |
| Do you have medical records or prescriptions?  If yes, please take pictures of every page of the record | | | | | Yes 1  No 2 | | | | | | |  | | | |
| **SECTION-8:- CURRENT AND LIFETIME DEPRESSIVE SYMPTOMS** | | | | | | | | | | | | | | | |
| **Part-8A:- PATIENT HEALTH QUESTIONNAIRE -9 (PHQ-9)** | | | | | | | | | | | | | | | |
|  | **Over the last 2 weeks, how often have you been bothered by any of the following problems (1-10)** | | | | | | | | | | | Not at All=1 ; Several Days=2; More than half the time=3 Nearly every day=4 | | | |
|  | Have little interest or pleasure in doing things | | | | | | | | | | |  | | | |
|  | Feeling down, depressed, or hope less | | | | | | | | | | |  | | | |
|  | Trouble falling or staying asleep or sleeping too much | | | | | | | | | | |  | | | |
|  | Feel tired or feel like having little energy | | | | | | | | | | |  | | | |
|  | Poor appetite or overeat | | | | | | | | | | |  | | | |
|  | Feeling bad about yourself – or that you are a failure or have let yourself or your family down | | | | | | | | | | |  | | | |
|  | Trouble concentrating on things, such as reading the newspaper or watching television | | | | | | | | | | |  | | | |
|  | 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 | | | | | | | | | | |  | | | |
|  | Thoughts that you be better off dead, or of hurting yourself in some way | | | | | | | | | | |  | | | |
|  | 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 | | | | | | | | | | | 1. Not difficult at all 2. Somewhat difficult 3. Very difficult 4. Extremely diffcult 5. NA | | | |
| **Part-8B: LIFETIME/ PAST DEPRESSION- *UK BIOBANK*** | | | | | | | | | | | | | | | |
| **Now we want to know some more about symptoms (related to your mood and feelings) in your lifetime** | | | | | | | | | | | | | | | |
|  | Have you ever had a time in your life when you felt sad, blue, or depressed for two weeks or more in a row? | | | | | | 1. Yes  2. No  3. Prefer not to answer | | | | |  | | | |
|  | Have you ever had a time in your life lasting two weeks or more when you lost interest in most things like hobbies, work, or activities that usually give you pleasure? | | | | | | 1. Yes  2. No  3. Prefer not to answer | | | | |  | | | |
| **If yes for Q1 and/or Q2 then go to Q3 OTHERWISE move to Section 9, if female. If male, thank him and end the questionnaire.** | | | | | | | | | | | | | | | |
|  | Did this worst period start within two months of the death of someone close to you or after a stressful or traumatic event in your life? | | | | | | 1. Yes  2. No  3. Prefer not to answer | | | | |  | | | |
|  | How much of the day did these feelings usually last? | | | | | | 1. less than half of the day  2. about half of the day  3. most of the day  4. All day long  5. Don’t know  6. Prefer not to answer | | | | |  | | | |
|  | How often did you feel this way? | | | | | | 1. less often  2. almost every day  3. every day  4. Don’t know  5. Prefer not to answer | | | | |  | | | |
|  | Did you feel more tired out or low on energy than usual? | | | | | | 1. Yes  2. No  3. Don’t know  4. Prefer not to answer | | | | |  | | | |
|  | Did you gain or lose weight without trying, or did you stay about the same weight | | | | | | 1. Gained Weight  2. Lost Weight  3. both gained and lost some weight during  the episode  4. Stayed about the same or was on a diet  5. Don’t know  6. Prefer not to answer | | | | |  | | | |
|  | Did your sleep change? | | | | | | 1. Yes  2. No  3. Don’t know  4. Prefer not to answer | | | | | **If yes, go to Q8a otherwise skip to Q9** | | | |
| 8a. | Was that: | | | | | |  | | | | |  | | | |
| 1. Trouble falling asleep | | | | | | 1. Yes 2. No | | | | |  | | | |
| 1. Waking too early | | | | | | 1. Yes 2. No | | | | |  | | | |
| 1. Sleeping too much | | | | | | 1. Yes 2. No | | | | |  | | | |
|  | Did you have a lot more trouble concentrating than usual? | | | | | | 1. Yes  2. No  3. Don’t know  4. Prefer not to answer | | | | |  | | | |
|  | People sometimes feel down on themselves, no good, worthless. Did you feel this way? | | | | | | 1. Yes  2. No  3. Don’t know  4. Prefer not to answer | | | | |  | | | |
|  | Did you think a lot about death – either your own, someone else’s or death in general? | | | | | | 1. Yes  2. No  3. Don’t know  4. Prefer not to answer | | | | |  | | | |
|  | For how long did you feel this way?  *Please also include the time before and after the two-week period when you may have experienced similar issues* | | | | | | 1. Less than a month  2. Between 1 and 3 months  3. Over 3 months but less than 6 months  4. Over 6 months but less than 12 months  5. 1-2yrs  6. >2yrs | | | | |  | | | |
|  | Think about your roles at the time of this episode, including study / employment, childcare and housework, leisure pursuits. How much did these problems interfere with your life or activities? | | | | | | 1. A little  2. Somewhat  3. A lot  4. Not at all  5. Prefer not to answer | | | | |  | | | |
| ***Regarding times in your life when you have had feelings of depression or loss of interest:*** | | | | | | | | | | | | | | | |
|  | How many periods did you have in your life lasting two or more weeks where you felt like this | | | | | | 1. One  2. Several  3. Prefer not to answer | | | | |  | | | |
|  | About how old were you the **FIRST** time you had a period of two weeks like this? (Whether or not you received any help for it.)  **(Age in completed years)** | | | | | | | | | | |  | | | |
|  | **For interviewer- Please ask this question to only married women**  Did this episode occur within months of giving birth? Or has it been suggested you had post-natal depression? | | | | | | 1. Yes  2. No  3. Not applicable  4. Don’t know  5. Prefer not to answer | | | | |  | | | |
|  | About how old were you the **LAST time** you had a period of two weeks like this? (Whether or not you received any help for it)  **(Age in completed years)** | | | | | | | | | | |  | | | |
|  | Did you ever tell a professional about these problems (medical doctor, psychologist, social worker, counsellor, nurse, clergy, or other helping professional)? | | | | | | 1. Yes  2. No  3. Don’t know  4. Prefer not to answer | | | | |  | | | |
|  | Did you ever try the following for these problems?  **(Multiple choice question)** | | | | | |  | | | | | | | Yes=1, No=2, Prefer not to naswer=3 | |
|  | 1. Medication prescribed to you, for at least 2 weeks | | | | | | |  | |
| 2. Unprescribed medication, which you have taken more than once | | | | | | |  | |
| 3. Drugs or alcohol, which you have taken more than once | | | | | | |  | |
|  | Did you ever try talking therapies for these problems, or other structured activities you regard as therapeutic? Include only those you attended more than once.  **(Multiple choice question)** | | | | | |  | | | | | | | Yes=1, No=2, Prefer not to naswer=3 | |
|  | 1. therapies, such as psychotherapy, counselling, group therapy or Cognitive Behavioural Therapy | | | | | | |  | |
| 2. Other therapeutic activities such as mindfulness, yoga or art classes | | | | | | |  | |
| **SECTION 9: FEMALE REPRODUCTIVE HISTORY (Only for Female)** | | | | | | | | | | | | | | | |
| THIS SECTION TO BE FILLED ONLY FOR THE **FEMALE PARTICIPANTS**. FOR MALE PARTICIPANTS SKIP THIS SECTION AND THANK THE PARTICIPANT | | | | | | | | | | | | | | | |
|  | Are you currently having menstrual cycles? | | | | | | 1. Yes 2. No | | | | **If “1” skip to Q9.4** | | | | |
|  | If ‘No’ what is the reason? | | | | | | 1- Pregnancy 2-Lactation 3-Natural menopause 4-Surgical menopause 5-Others | | | | “If “5” then please specify | | | | |
|  | If menopausal, since how long? **[Ask if Q9.2 is filled with option 3 or 4]** | | | | | | YY Month | | | | | | | | |
|  | 9.4a If the participant cannot recall the date of her LMP | | | | | | DD MM YY | | | | | | | | |
|  | Number of pregnancies so far?  **[also include miscarriages/abortions]** | | | | | | **If “00” end the questionnaire”** | | | | | | | | |
|  | In the last pregnancy was the delivery : | | | | | | 1. Normal  2. Caesarian Section  3. Other’s  9. Not applicable | | | | **If others (option 3), then**  **specify** | | | | |
|  | Were you diagnosed to have gestational diabetes in any of the pregnancies? | | | | | | 1. Yes  2. No | | | |  | | | | |
|  | Were you diagnosed to have hypertension in any of the pregnancies | | | | | | 1. Yes  2. No | | | |  | | | | |
|  | What is the **date** of birth of your youngest biological child?  **If the participant is able to recall then end the questionnaire otherwise fill 9.9a** | | | | | | DD MM YY | | | | | | | | |
|  | What is the age of your youngest biological child? | | | | | | YY Month | | | | | | | | |

**END TIME:-   
 HOURS MINUTES**