Participant ID

CARRS: Surveillance Study

Instruction to the interviewer: HAS THE PARTICIPANT SIGNED THE INFORMED CONSENT? DO NOT PROCEED UNTIL THE CONSENT FORM HAS BEEN SIGNED.

Household ID	Participant ID
CEB Code	Interviewer ID
Date of interview: DD/ MM/ YY	Start Time [Hr:min] HR : MIN

SECTION – 1: DEMOGRAPHIC, SOCIO-ECONOMIC AND RESIDENTIAL DETAILS

1.Name of the Participant: First name: Middle Name: Surname:	 _____ _____ _____
2.Father's/Spouse's name: First name: Middle Name: Surname:	 _____ _____ _____
3.Address/Details: Street: District: State: Postal Code:	
5.Telephone Number Residence Office Mobile	 _____ _____ _____
6.Email ID	(1) (2)
7.Place of Birth District: State:	
8.Age (in completed years)	
9.Date of birth (if available)	DD / MM / YYYY

10.Sex	Male 1 Female 2 Trans-gender 3	☐
11.What is your marital status?	Single 1 Married 2 Widow/Widower 3 Separated/Divorced 4 Others 5	☐ Others, specify _____
12.What is your mother tongue? (State of origin)	Assamese 1, Balochi 2, Bengali 3, Gujarati 4, Hindi 5, Kannada 7, Kashmiri 8, Maithili 9, Malayalam 10, Marathi 11, Punjabi 14, Sindhi 15, Telugu 16, Tamil 17, Urdu 18, Others 19	☐☐ Others, specify _____
13.What religion do you follow? (Optional)	Hindu 1 Muslim 2 Sikh 3 Christian 4 Jain 5 Buddhism 6 No religion 7 Others (specify) 8 No response 9	☐ Others, specify _____
14.Do you belong to a particular caste or tribe? (Optional)	Yes 1 No 2 Don't know 3 Don't want to answer 4 Not applicable 5	☐
14.a. If "Yes" What is your caste or tribe? (Optional)	Schedule caste 1 Schedule tribe 2 Other backward caste 3 Most backward 4 Others 5 Don't want to answer 6	☐ Others (specify) _____
15.Number of years of formal education* * The total number of years the participant spent in any educational institution (schools, colleges, religious schools, etc.)		☐☐ **years**

16. Educational status (highest attained degree) ** A person who can both read and write with understanding in any language without any formal education or passed any minimum educational standard.* *** A person, who can neither read nor write or can only read but cannot write in any language.*	Professional degree/post graduate 1 Graduate (B.A/B.Sc/B.Com/Diploma) 2 Secondary School / Intermediary (ITI course, class XII/X or Intermediate) 3 High school (class V to IX) 4 Primary School (upto Class IV) 5 *Literate, no formal education 6 **Illiterate 7 Others 8	Others, specify _____ _____
17. Your employment status?	Employed 1 Student 2 Housewife 3 Retired 4 Un-employed 5	**"1" go to 17.a Otherwise go to Q18**
17.a. If ***"Employed",*** what is your current occupation? ***[Use nearest applicable employment codes given below]***		
18. Have you been involved in any other occupation during past ten years?	Yes 1 No 2	**"2" go to Q. 19**
18.a. If ***'YES',*** name the occupation? ***[Use nearest applicable employment codes given below]***		

Coding list for employment (for Q.17.a and Q.18.a)- refer to annexure for definition of skilled, semi-skilled, un-skilled

Professional, big business, landlord, university teacher, class 1 IAS/services officer, lawyer	1
Trained, clerical, medium business owner, middle level farmer, teacher, maintenance (in charge), personnel manager	2
Skilled manual labourer, small business owner, small farmer	3
Semi-skilled manual labourer, marginal landowner, rickshaw driver, army jawan, carpenter, fitter	4
Unskilled manual labourer, landless labourer	5

19. What is your total household income per month? ***Please include income from all members 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 Refuse 8 Don't know 9	
20. Do you have a separate room for cooking (Kitchen)?	Yes 1 No 2	

21. 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 Electricity/gas (LPG)/solar/CNG (IGL) 2 Wood/dung 3 Others 4	☐ Others (specify) _____
22. What is the source of drinking water used at home? ***If more than one source is used then note the source that is most commonly used***	Public source 1 Private source (Shared) 2 Private source (Own) 3 Bottled water 4 Purified tap water 5 Others 6	☐ Others (specify) _____
23. What is the toilet facility you use?	Public toilet 1 Shared toilet 2 Own flush toilet 3 Others 4	☐ Others (specify) _____
24. Which of the following do you own? ***[Yes=1; No=2]***	a. Television b. Refrigerator c. Washing machine d. Microwave / OTG e. Mixer-grinder f. Mobile phone g. DVD player h. Computer i. Car j. Motor Cycle /Scooter k. Bicycle	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
25. Are you likely to move from your current residence within a year or two?	Yes 1 No 2 Don't know 3	☐
26. In case you move from current residence, whom can we contact to obtain your new contact address or telephone numbers? ***Take details of two different contacts***	Neighbour 1 Relative 2 Friend 3 Employer 4 No one to contact 5 Others 6 Specify _____	1st ☐ 2nd ☐
27. Name of the 1st contact person First Name: Middle name: Last Name:		

28.Address of the 1st contact person	
29.Phone number (home, office, mobile) of 1st contact person	Home _____(area code)_____(number) Office _____(area code)_____(number) Mobile_____(number)
30.Name of the 2nd contact person First Name: Middle Name: Last Name:	
31.Address of the 2nd contact person	
32.Phone number (home, office, mobile) of 2nd contact person	Home _____(area code)_____(number) Office _____(area code)_____(number) Mobile_____(number)

SECTION – 2: TOBACCO AND ALCOHOL CONSUMPTION, DIETARY HABITS, PHYSICAL ACTIVITY AND SLEEP

PART – A: TOBACCO USE

1. Have you ever used tobacco in any form (smoking, chewing, snuff, etc)?	Yes 1 No 2	**"2" go to Q. 8**
2. In what forms have you consumed tobacco? ***[Yes=1; No=2]***	a. In a smoking form b. In a chewed form c. In any other form (snuff, toothpaste etc)	
3. Do you currently* consume tobacco? * within past 6 months	Yes 1 No 2	**"2" go to Q. 5**
4. If Yes, how often? ***[Regularly (≥ once a week)= 1; Occasionally (<once a week)= 2; No=3; Not applicable=9]***	Smoking form / Chewed form / Any other form	

5. Quantity and duration of use (for both current and past users)

Type of tobacco use / used	***Brand name***	***Duration of use***		***Usage per month*** ****Number smoked*** *****Number of times*** ******Approximate amount in gms***	***If you have stopped using any of the following products, time in months/years since you have stopped***	
		Years	***Months***		***Years***	***Months***
1. Cigarette*						
2. Beedi*						
3. Cigar*						
4. Hukka/Chelum/Pipe **						
5. Tobacco chewing***						
6. Pan with Zarda***						
7. Pan masala with zarda***						
8. Snuff**						
9. Gutkha***						
10. Others: Specify _____						

6. At what age did you first start smoking regularly?
   [Not applicable – write '99' in the box] — ☐☐ **years**

7. At what age did you first start consuming smokeless tobacco product regularly?
   [Not applicable – write '99' in the box] — ☐☐ **years**

8. Are you exposed to tobacco smoke from others regularly*? (e.g. at home, at workplace regularly, while travelling, any other place)
   * At least once a day in a week

   Yes 1
   No 2

   ☐ **"2" go to PART B**

9. **If Yes**:
   How many days a week*? ☐
   How much time during a day*? ☐☐ : ☐☐ HR MIN (Please provide approximate time)

PART – B: ALCOHOL USE

1. Have you ever used alcohol?

   Yes 1
   No 2

   ☐ **"2" go to PART C**

2. How often do you use alcoholic beverages? ***Occasionally means less than once a week***	Currently using alcohol regularly 1 Currently using alcohol occasionally* 2 Used alcohol in the past (stopped more than 6 months ago) 3 Recently stopped alcohol (less than 6 months ago) 4 Never used alcohol 5	**"5" go to PART C**

3. History of alcohol use for both present and past users

Type of alcohol used	***Duration of use***		***Frequency of use per week***	***Quantity**** *in ml/peg per occasion*	**If stopped, since how long**	
	Years	**Months**			**Years**	**Months**
a) Local spirits eg. Desi, arrack, toddy etc						
b) Spirits eg. whisky, rum, brandy, gin, vodka						
c) Beer						
d) Wine						

** Conversion

1 small peg = 30 ml; 1 large peg = 60 ml; 1 extra large peg = 90 ml

1 glass of beer = approx. 325 ml

1 glass of wine = 100 ml

Please use local measures in calculating the total consumption (in ml per occasion)

PART – C: PHYSICAL ACTIVITY (International Physical Activity Questionnaire – short)

We are interested in finding out about the kinds of physical activities that people do as part of their everyday lives. I am going to ask you about the time you spent being physically active in the usual 7 days of a week. Please answer each question even if you do not consider yourself to be an active person. Think about the activities you do at work, as part of your house and yard work, to get from place to place, and in your spare time for recreation, exercise or sport.

Now, think about all the *vigorous* activities that you did in a usual 7 days. Vigorous activities make you breathe much harder than normal and may include heavy lifting, digging, aerobics, or fast bicycling. Think only about those physical activities that you do for at least 10 minutes at a time.

1. During **a usual 7 days**, on how many days did you do **vigorous** physical activities?	Days per week = 1 Refused (go to Q.3) = 2 Don't Know/Not Sure (go to 3) = 3 Don't do any activity (go to 3) = 4	
2. How much time did you usually spend doing **vigorous** physical activities on one of those days? Think only about those physical activities you do for at least 10 minutes at a time.	Hours/ Minutes per day = 1 Refused (go to Q.2a) = 2 Don't Know/Not Sure (go to 2a) = 3	HR : MIN

2a. **Interviewer probe:** If the respondent can't answer because the pattern of time spent varies widely from day to day, say, "I am interested in the average time for one of the days on which you do vigorous activity. Can you tell me how much time in total would you spend **over a usual 7 days** doing vigorous physical activities?"	Hours/ Minutes per day = 1 Refused = 2 Don't Know/Not Sure = 3	HR : MIN
Now think about activities which take *moderate physical effort* that you did in a usual 7 days. Moderate physical activities make you breathe somewhat harder than normal. Do not include walking. Again, think about only those physical activities that you did for at least 10 minutes at a time.		
3. During a **usual 7 days**, on how many days did you do **moderate** physical activities for at least 10 minutes? Examples: carrying loads, bicycling at a regular pace, tennis, badminton, cricket, hand washing clothes, sweeping the floor, gardening, taking care of children less than three years old, washing cars, motorcycles, or scooters, walking home while carrying vegetables and groceries from market, climbing stairs (three floors or more), and grinding chutney on stone.	Days per week =1 Refused (go to Q.5) = 2 Don't Know/Not Sure (go to Q.5) = 3 Don't do any activity (go to Q.5) = 4	
4. How much time did you usually spend doing **moderate** physical activities on one of those days? Think only about those physical activities that you do for at least 10 minutes at a time.	Hours/ Minutes per day=1 Refused (Go To Q.4a) = 2 Don't Know/Not Sure (Go To Q.4a)=3	HR : MIN
4a. **Interviewer probe**: If the respondent can't answer because the pattern of time spent varies widely from day to day, or includes time spent in multiple jobs, say, "I am interested in the average time for one of the days on which you do moderate activity. Can you tell me what is the total amount of time you spent over a **usual 7 days** doing moderate physical activities?"	Hours/ Minutes per day=1 Refused = 2 Don't Know/Not Sure = 3	HR : MIN
Now think about the time you spent walking in a usual 7 days. This includes at work and at home, walking to travel from place to place. Also include any walking that you do solely for recreation, sport, exercise, or leisure, for example, walking to the bus stop, to workplace, to the market for at least 10 minutes.		
5. During a **usual 7 days**, on how many days did you **walk** for at least 10 minutes at a time? Think only about the walking that you do for at least 10 minutes at a time.	Days per week = 1 Refused (go to Q. 7) = 2 Don't Know/Not Sure (go to Q. 7) =3 Don't do any activity (go to Q. 7) = 4	
6. How much time did you usually spend **walking** on one of those days?	Hours/ Minutes per day (go to Q. 7) =1 Refused (go to Q.6a) = 2 Don't Know/Not Sure (go to Q6a) =3	HR : MIN
6a. **Interviewer probe**: If the respondent can't answer because the pattern of time spent varies widely from day to day say, "I am interested in the average time for one of the days on which you walk. Can you tell me what is the total amount of time you spent walking over **a usual 7 days**?"	Hours/ Minutes per week =1 Refused =2 Don't Know/Not Sure =3	HR : MIN
Now think about the time you spent sitting on week days during a usual 7 days. Include time spent at work, at home, while doing course work, and during leisure time. This may include time spent sitting at a desk, visiting friends, reading or sitting or lying down to watch television, cutting vegetables, sewing and knitting, or time spent in teaching children, performing religious prayers, chatting with friends, talking on the phone, or working in front of the computer.		

7. During a usual 7 days, how much time did you usually spend ***sitting*** on a **weekday**? Include time spent lying down (awake) as well as sitting. *(*Exclude sleeping at night)*	Hours/ Minutes per week day (go to Q. 8)=1 Refused (go to Q. 7a) = 2 Don't Know/Not Sure(go to Q7a) = 3	HR : MIN
7a**. Interviewer probe**: If the respondent can't answer because the pattern of time spent varies widely from day to day, say "I am interested in the average time per day spent sitting. Can you tell me what is the total amount of time you spent *sitting* last **Wednesday**?"	Hours/ Minutes on Wednesday = 1 Refused =2 Don't Know/Not Sure =3	HR : MIN
8. Additional comments		

PART – D: SLEEP (Sleep Heart Health Study; NHLBI)

1. How many hours of sleep do you usually get at night (or your main sleep period)? **Average hours of sleep per night**	On weekdays / workdays No. of hrs	On weekends No. of hrs
2. During a usual week, how many times do you nap for 5 minutes or more? (Write "00" if the participant does not take any naps)	No. of times	

3. Please indicate how often you experience each of the following **(refer to codes below)**
[Never=1; Rarely (1/month or less)=2; Sometimes (2-4/month)=3; Often (5-15/month)=4; Almost always (16-30/month)=5]

A. Have trouble falling asleep
B. Wake up during the night and have difficulty getting back to sleep
C. Wake up too early in the morning and be unable to get back to sleep
D. Feel unrested during the day, no matter how many hours of sleep you had
E. Do not get enough sleep
F. Take sleeping pills or other medication to help you sleep

Questions 4 to 10 are about snoring and breathing during sleep. To answer these questions please consider what other have told you and what you know about yourself

4. Have you ever snored (now or any time in the past)?	Yes No Don't know	1 2 8	**"2", "8" go to Q.7**
5. How often do you snore now?	Do not snore anymore Rarely (<1 night/week) Sometimes (1-2 nights/week) Frequently (3-5 nights/week) Always or almost always(6-7nights/week) Don't know	0 1 2 3 4 8	**"0" go to Q.7**
6. How loud is your snoring?	Only slightly louder than heavy breathing About as loud as mumbling or talking Louder than talking Extremely loud-can be heard through a closed door Don't know	1 2 3 4 8	

7. Based on what you have noticed or household members have told you, are there times when you stop breathing during your sleep?	Yes 1 No 2 Don't know 8	**"2", "8" go to Q.9**
8. How often do you have times when you stop breathing during your sleep?	Rarely (<1 night/week) 1 Sometimes (1-2 nights/week) 2 Frequently (3-5 nights/week) 3 Always or almost always(6-7nights/week) 4 Don't know 8	
9. Have you ever been told by a doctor that you had sleep apnoea (a condition in which breathing stops briefly during sleep)?	Yes 1 No 2 Don't know 8	**"1" go to Q.11** **"2", "8" go to Q.10**
10. Have you ever been told by a doctor that you had some other sleep disorder?	Yes 1 No 2 Don't know 8	**"2", "8" go to Q.11**
10.A. If response is "yes" to the above question, please specify the disorder _____ _____		
11. Do you usually use oxygen therapy (oxygen delivered by a mask or nasal cannula) during your sleep?	Yes 1 No 2	
12. During the past year how often have one or more members of your household been in or near the room where you have slept?	Never 1 Sometimes 2 Usually 3	

13. **What is the chance that you would doze off or fall asleep (not just "feel tired") in each of the following situations? (refer to the codes below)**

[No chance=1; Slight chance=2; Moderate chance=3; High chance=4]

*If you are never or rarely in the situation, please give your **best guess** for the situation*

A. Sitting and reading

B. Watching TV

C. Sitting inactive in a public place (such as a theatre or a meeting)

D. Riding as a passenger in a car for an hour without a break

E. Lying down to rest in the afternoon when circumstances permit

F. Sitting and talking to someone

G. Sitting quietly after a lunch

H. In a car, while stopped for a few minutes in traffic

I. At the dinner table

J. While driving

14. How often do you take aspirin or aspirin-containing medicines?	Never 1 Less often than once a week 2 Once or twice a week 3 Every other day (one day out of two) 4 Every day 5 Don't know 8	
15. Do you drive?	Yes 1 No 2	"2" go to Part E

16. **If the response to the above question is "yes" please answer the following questions, else go to Part-E (Diet)**

A. No. of years of driving

B. How often do you drive?
[Everyday=1; sometimes=2; rarely/never=3]

C. Since you began driving, how many accidents have you had while you were the driver?

D. How many accidents have you had in the last year while you were the driver?

PART – E: DIET

1. Are you a vegetarian?	Yes 1 No 2	
2. Do you take eggs?	Yes 1 No 2	
3. Are you on any special diet?	Yes 1 No 2	"2" go to Q.6
4. If ***YES***, what diets are you currently following ***[Yes = 1; No = 2]***	Diabetic diet Low fat diet High fibre diet Low salt diet Weight reducing diet Others (Specify) _____	

5. Since how many years are you on this special diet? Yrs ____ Mnts ____ [Enter the the longest duration]

6. How frequently do you use reheated oil?	Every day 1 Every other day (one day out of two) 2 Once or twice a week 3 Less often than once a week 4 Never 5	

5. In the past one year, how often have you consumed foods from the following food groups? **[write the frequency of consumption in the appropriate column]**

Sl. No.	Food groups	Consumed never/less than once /month [√]	Consumed monthly	Consumed weekly	Consumed daily
1	**Meats**				
2	**Poultry**				
3	**Organ meats**				

4	**Fish**				
5	**Shell fish and crustaceans**				
6	**Eggs**				
7	**Milk and milk products**				
8	**Milk based desserts**				
9	**Deep fried foods: western style**				
10	**Deep fried foods: desi style**				
11	**Western style desserts/sweet snacks**				
12	**Mithai**				
13	**cold beverages**				
14	**Fruits (1)**				
15	**Fruits (2)**				
16	**Fruit juices**				
17	**Nuts/seeds**				
18	**Leafy greens**				
19	**Other raw vegetables**				
20	**Legumes and pulses**				
21	**Use of pickles, pickled foods**				
22	**Other cooked vegetables**				
23	**Refined cereals with less fibre**				
24	**Whole grain**				
25	**Tea consumption**				
26	**Coffee consumption**				

Annex for food groups [showing items in each group]

Meat [lamb, mutton, goat, veal, rabbit, beef, pork; their curries]
Poultry [chicken, turkey, duck, pheasant, quail; their curries]
Organ meats [liver, kidney, brain, spleen, heart and sausages nihari, paya]
Fish [fresh-water and sea-water fish; preserved fish such as salted fish, canned fish, dried fish]
Shell fish and crustaceans [crab, squid, prawns, molluscs, caviar]
Eggs [Includes preserved eggs, duck eggs]
Milk and milk products: [milk, yogurt, cheese, curd, raita, lassi, milk based drinks]
Milk based desserts [custard, khoya, firni, kheer, milk puddings, rasgullah/rasmalai, ice creams]all milk based desserts
Deep fried foods: western style [french fries, potato chips, onion rings, chicken nuggets]
Deep fried foods: desi style [samosas, papad, pakoras, sev, namak paray, egg rolls, poori, kachori]
Western style desserts/sweet snacks [cakes; pies; chocolate; candy; biscuits]
Mithai [burfi/ladoo; gulab jamun; halwa; shameia, mohalabeia]
Cold beverages [carbonated beverages, sherbets, and other soft drinks]
Fruits (1) [strawberries, pine apples, jumbo berries (jamuns), apples]
Fruits (2) all seasonal fruits except the ones above
Fruit juices [any type, homemade, purchased, fresh, frozen]
Nuts/seeds [Includes peanuts, almonds, sunflower seeds, cashews, walnuts]
Leafy greens [all fresh leafy green vegetables: spinach, mustard or turnip greens; asparagus either raw or cooked]
Other raw vegetables [any raw vegetables not included in the preceding categories]
Legumes and pulses [includes all daals, chickpeas, lentils]
Use of pickles, pickled foods [achar, chutneys, pickled vegetables etc]
Other cooked vegetables [any cooked vegetables not included in the preceding categories]
Refined cereals with less fibre [boiled rice, fried rice, biryani, pulao, idli, dosa, semolina,sago, pearl barley, pasta, sheermal, taftan, white bread slice]
Whole grain (cereal dished with more fibre) [Roti made with whole meal flour, brown rusk, whole wheat porridge, bread slice whole meal/brown]
Tea consumption [black tea, coffee with and without milk and sugar and any other tea]
Coffee consumption [coffee with and without milk and/sugar]

SECTION – 3: FEMALE REPRODUCTIVE HISTORY

THIS SECTION IS TO BE FILLED ONLY FOR THE FEMALE PARTICIPANTS, FOR MALE PARTICIPANTS SKIP THIS SECTION AND GO TO SECTION – 4.

1. Number of pregnancies so far? ***Not Applicable = 99***	

2. At what age did you start menstruating?	Years		
3. Are you having menstrual cycles?	Yes No	1 2	**"1" go to Q. 6**
4. If '**No**' what is the reason?	Pregnancy Lactation Natural menopause Surgical menopause Other reasons(specify)	1 2 3 4 5	***Others, specify***_____
5. If postmenopausal, since how long?	Years		Months
6. Hormonal drugs or oral contraceptive pills? ***[Yes = 1; No = 2]***	Ever used in the past		If Yes, duration in years/month Yrs Mnts
	Currently using		If Yes, duration in years/month Yrs Mnts

SECTION – 4: QUALITY OF LIFE (EQ-5D) © 1990 EuroQol Group. EQ-5D™ is a trade mark of the EuroQol Group.

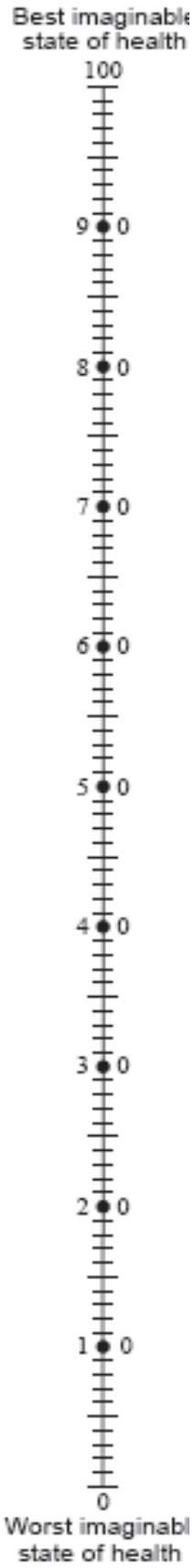
By writing a code from the options in the box, please indicate which statements best describe your own state of health today.

1. Mobility	I have no problems in walking about=1 I have some problems in walking about=2 I am confined to bed=3	
2. Self-Care	I have no problems with self-care=1 I have some problems washing or dressing myself=2 I am unable to wash or dress myself=3	
3. Usual Activities *(e.g. work, study, housework, family or leisure activities)*	I have no problems with performing my usual activities=1 I have some problems with performing my usual activities=2 I am unable to perform my usual activities=3	
4. Pain/ Discomfort	I have no pain or discomfort=1 I have moderate pain or discomfort=2 I have extreme pain or discomfort=3	
5. Anxiety/ Depression	I am not anxious or depressed=1 I am moderately anxious or depressed=2 I am extremely anxious or depressed=3	

To help people say how good or bad their state of health is, we have drawn a scale (rather like a thermometer) on which the best state you can imagine is marked 100 and the worst state you can imagine is marked 0.

I would like you to indicate on this scale how good or bad your own health is today, in your opinion. Please do this by drawing a line from the box below to whichever point on the scale indicates how good or bad your state of health is today.

Your own state of health today



SECTION – 5: MEDICAL HISTORY

PART-A: CARDIOMETABOLIC DISEASES AND THEIR RISK FACTORS

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]***	Hypertension (High blood pressure) Diabetes (High Blood Sugar) Hyperlipidemia (High Cholesterol) Heart Disease Stroke (Paralytic Attack) Chronic Kidney Disease	

**Exclude pregnancy induced Hypertension and High Blood Sugar*

*If the answer is **'YES'** to any of the choices in Q. 1, then go to PART – B **'OTHERWISE'** skip the entire section and go to PART-C.*

PART - B: DISEASE SPECIFIC QUESTIONS

I. HYPERTENSION (High Blood Pressure)

Fill this section if the answer for high blood pressure is "YES" in PART - A, Q.1.

a. Since how many years have you had high blood pressure?		Duration in years/month Yrs ☐☐ Mnts ☐☐
b. What treatment are you taking for it currently? ***[Yes=1; No=2]*** ****Traditional medicine / therapy include yoga, ayurveda, unani, homeopathy, Tibetan, naturopathy, meditation***	Prescribed dietary modifications Prescribed physical exercise Traditional medicine / therapy* Allopathic drugs (English / modern) None	
c. How regular are you in taking your medicines?	Taking Regularly 1 Forget to take occasionally 2 Take medicines only when I feel the blood pressure is high 3 Discontinued for more than a month at a time 4 Never taken any medication 5	
If "4" go Q.d otherwise go to Q.e.		
d. What is the reason for discontinuation?	Cannot afford 1 Cannot tolerate 2 I have recovered 3 No reason 4 Don't remember 5 Others (specify) 6	***Others, specify*** _____
e. Do you think your blood pressure is under good control?	Yes 1 No 2 Don't Know 3	

f. Does your doctor say that your blood pressure is under good control?	Yes 1 No 2 Don't Know 3	
g. What was your last blood pressure recording (when your doctor checked you)? = 1 Don't know = 2 Can't remember = 3	_____(systolic) / _____(diastolic) mmHg	
h. When was the last time you consulted your doctor?	Less than 1 month 1 More than 1 month 2 More than 3 months 3 Less than 6 months 4 More than 6 months 5	
i. Do you have medical records or prescriptions related to high blood pressure?	Yes 1 No 2 Don't Know 3	
*j. If the answer is **YES,** ask the participant to show the medical records and note the diagnosis below*		
k. Note the recorded blood pressure from the most recent medical record / prescription _____(systolic) / _____(diastolic) mmHg		
II. DIABETES Fill this section if the answer for high blood sugar is **"YES"** in PART-A, Q.1		
a. For how long have you had high blood sugar / diabetes?	Duration in years/month Yrs Mnts	
b. What treatment are you taking for it currently? ***[Yes=1; No=2]*** ****Traditional medicine / therapy include yoga, ayurveda, unani, homeopathy, Tibetan, naturopathy, meditation***	Prescribed dietary modifications Prescribed physical exercise Traditional medicine / therapy* Allopathic drugs (English / modern) None	
c. How regular are you in taking your medicines?	Taking Regularly 1 Forget to take occasionally 2 Take medicines only when I feel the blood sugar is high 3 Discontinued for more than a month at a time 4 Never taken any medication 5	
If "4" go Q.d otherwise go to Q.e.		

d. What is the reason for discontinuation?	Cannot afford 1 Cannot tolerate 2 I have recovered 3 No reason 4 Don't remember 5 Others (specify) 6	***Others, specify*** _____
e. Do you think your diabetes/high blood sugar is under good control?	Yes 1 No 2 Don't Know 3	
f. Does your doctor say that your diabetes /high blood sugar is under good control?	Yes 1 No 2 Don't Know 3	
g. What was your fasting blood sugar and after meal blood sugar when you got it checked last time?	Fasting _____mg/dl After meal _____mg/dl	
h. When was the last time you consulted your doctor?	Less than 1 month 1 More than 1 month 2 More than 3 months 3 Less than 6 months 4 More than 6 months 5	
i. Do you have medical records or prescriptions related to diabetes/high blood sugar?	Yes 1 No 2 Don't Know 3	

j. *If the answer is **YES,** ask the participant to show the medical records and note the diagnosis below*

k. ***Note the recorded fasting blood sugar and after meal blood sugar level from the most recent medical record / prescription***

Fasting_____mg/dl

After meal_____mg/dl

Also complete PART – D

III. HYPERLIPIDEMIA or High Blood Cholesterol

Fill this section if the answer for high blood cholesterol is "yes" in PART-A, Q.1

a. For how long have you had high blood cholesterol?	Duration in years/month Yrs ☐☐ Mnts ☐☐	
b. What treatment are you taking for it currently? ***[Yes=1; No=2]*** ****Traditional medicine / therapy include yoga, ayurveda, unani, homeopathy, Tibetan, naturopathy, meditation***	Prescribed dietary modifications Prescribed physical exercise Traditional medicine / therapy* Allopathic drugs (English / modern) None	☐ ☐ ☐ ☐ ☐
c. How regular are you in taking your medicines?	Taking Regularly 1 Forget to take occasionally 2 Take medicines only when I feel the blood cholesterol is high 3 Discontinued for more than a month at a time 4 Never taken any medication 5	☐
If "4" Q.d otherwise go to Q.e		
d. What is the reason for discontinuation?	Cannot afford 1 Cannot tolerate 2 I have recovered 3 No reason 4 Don't remember 5 Others (specify) 6	☐ ***Others, specify*** _____
e. Do you think your cholesterol is under good control?	Yes 1 No 2 Don't Know 3	☐
f. Does your doctor say that your cholesterol is under good control?	Yes 1 No 2 Don't Know 3	☐
g. What was total cholesterol level when you last checked it?	_____ mg/dl	
h. When was the last time you consulted your doctor?	Less than 1 month 1 More than 1 month 2 More than 3 months 3 Less than 6 months 4 More than 6 months 5	☐

i. Do you have medical records or prescriptions related to high blood cholesterol?	Yes 1 No 2 Don't Know 3	
*j. If the answer is **YES,** ask the participant to show the medical records and note the diagnosis below*		
k. Note the recorded total cholesterol from the most recent medical record / prescription		
IV. HEART DISEASE **Fill this section if the answer for heart trouble is "YES" in PART-A, Q.1**		
a. When did you first come to know that you have heart disease?	**<**1 year 1 1-5 years 2 >5 years 3	
b. What did the doctor say it was?	Heart attack 1 Angina 2 Heart failure 3 Valve disease 4 Hole in the heart 5 Others* 6 Not informed about the nature of the problem 7	Use separate boxes for more than one option ***Others, specify*** _____
If "1" go to Q.c otherwise go to Q. g.		
c. At what age did you have your 1st heart attack?	Years	
d. Were you hospitalized for treatment?	Yes 1 No 2	
e. Did you have any repeat attacks	Yes 1 No 2	
f. Were you hospitalized for the subsequent attacks	Yes 1 No 2	

g. What treatment are you taking for heart disease currently? ***[Yes=1; No=2]*** ****Traditional medicine / therapy include yoga, ayurveda, unani, homeopathy, Tibetan, naturopathy, meditation***	Prescribed dietary modifications Prescribed physical exercise Traditional medicine / therapy* Allopathic drugs (English / modern) None	
h. How regular are you in taking your medicines?	Taking Regularly 1 Forget to take occasionally 2 Take medicines only when I feel unwell 3 Discontinued for more than a month at a time 4 Never taken any medication 5	
If "4" go to Q.i question otherwise go to Q.j.		
i. What is the reason for discontinuation?	Cannot afford 1 Cannot tolerate 2 I have recovered 3 No reason 4 Don't remember 5 Others (specify) 6	***Others, specify*** _____
j. When was the last time you consulted your doctor?	Less than 1 month 1 More than 1 month 2 More than 3 months 3 Less than 6 months 4 More than 6 months 5	
k. Do you have medical records or prescriptions related to heart trouble?	Yes 1 No 2 Don't Know 3	
l. ***If the answer is 'YES', ask the participant to show the medical records and note the diagnosis below***		

V. STROKE (Paralytic attack) **Fill this section if the answer for stroke (paralytic attack) is "yes" in PART-A, Q.1**		
a. What was your age when you had stroke (Paralytic attack)?	Years	
b. Is there a residual disability in any part of the body?	Yes 1 No 2	
c. If **'YES'**, does it involve the following? ***[Yes=1; No=2]***	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 (specify)_____	
d. Are you advised to continue any medication after your paralytic attack?	Yes 1 No 2	
e. If **YES**, how regular are you in taking your medicines?	Taking Regularly 1 Forget to take occasionally 2 Take medicines only when I feel unwell 3 Discontinued for more than a month at a time 4 Never taken any medication 5	
If "4" go to Q.f otherwise go to Q.g.		
f. What is the reason for discontinuation?	Cannot afford 1 Cannot tolerate 2 I have recovered 3 No reason 4 Don't remember 5 Others (specify) 6	***Others, specify*** _____
g. When was the last time you consulted your doctor?	Less than 1 month 1 More than 1 month 2 More than 3 months 3 Less than 6 months 4 More than 6 months 5	
h. Do you have medical records or prescriptions related to Stroke?	Yes 1 No 2 Don't Know 3	

i. *If the answer is **YES**, ask the participant to show the medical records and note the diagnosis below*

VI. CHRONIC KIDNEY DISEASE

Fill this section if the answer for chronic kidney disease is "YES" in PART-A, Q.1

a. At what age were you diagnosed with chronic kidney disease?	Years	
b. What treatment are you taking for it currently? ***[Yes=1; No=2]*** ****Traditional medicine / therapy include yoga, ayurveda, unani, homeopathy, Tibetan, naturopathy, meditation***	Prescribed dietary modifications Prescribed physical exercise Traditional medicine / therapy* Allopathic drugs (English / modern) None	
c. How regular are you in taking your medicines?	Taking Regularly 1 Forget to take occasionally 2 Take medicines only when I feel unwell 3 Discontinued for more than a month at a time 4 Never taken any medication 5	
If "4" go Q.d otherwise go to Q. e.		
d. What is the reason for discontinuation?	Cannot afford 1 Cannot tolerate 2 I have recovered 3 No reason 4 Don't remember 5 Others (specify) 6	***Others, specify*** _____
e. When was the last time you consulted your doctor?	Less than 1 month 1 More than 1 month 2 More than 3 months 3 Less than 6 months 4 More than 6 months 5	
f. Do you have medical records or prescriptions related to chronic kidney disease?	Yes 1 No 2 Don't Know 3	

g. *If the answer is **YES,** ask the participant to show the medical records and note the diagnosis below*

PART - C: ANGINA, PERIPHERAL VASCULAR DISEASE AND HEART FAILURE

I. ANGINA

a. Do you have any of the following symptoms?

[Yes=1; No=2]

Palpitation
Chest pain
Breathlessness
Fatigue/weakness
Chest discomfort/heaviness/pressure

"2" for all, skip to Q. m

b. With exertion*, have you ever had any of the following symptoms in and around the chest, arms, shoulders, neck, lower jaw, abdomen or upper back?

*walking fast, climbing stairs, lifting weights, etc

[Yes=1; No=2]

Pain
Heaviness
Pressure
Discomfort
Numbness

"2" for all, skip to Q. d

c. Where did you mostly feel the (symptoms noted in Q.b)?

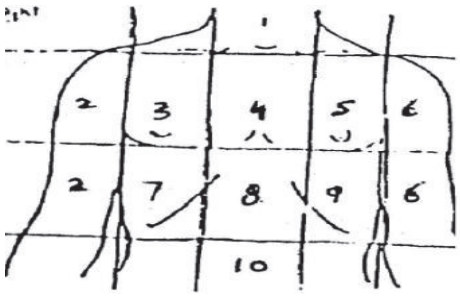
[Yes=1; No=2]

(Please specify the location from the numbered diagram below)

Additional numbers: back of chest = 11, back of neck = 12)

	Symptom	***Location***
Pain		
Heaviness		
Discomfort		
Numbness		

Right



Left

d. Do you feel any of the above symptoms anywhere else?

Yes 1
No 2

*If **'YES'**, specify:*
Symptom:_____
Location:_____

Fill Q.e to Q.l only if you have noted "1" for any of the symptoms in Q.b and Q.c, OTHERWISE GO TO Q.m

e. Do you get the above symptoms, or breathlessness, or palpitation when you walk uphill or climb steps or walking fast?	Yes 1 No 2 Never walk uphill/hurry 3	
f. Do you get it when you walk at an ordinary pace on the level ground?	Yes 1 No 2	
g. Do you get a similar symptoms while you are resting or after a meal?	Yes 1 No 2	
h. What do you usually do if you get it while you are exerting?	Stop 1 Slow down 2 Carry on at the same pace 3	
i. Does it go away if you slow down or stand still?	Yes 1 No 2	**"2" go to Q.k**
j. If `***YES'*** to Q. i, how soon does it usually go away?	< 3 mins 1 3-20 mts 2 >20 mts 3	
k. Do you take usually a pill under the tongue to get relief?	Yes 1 No 2	**"2" go to Q.m**
l. If `***YES'***, how soon does it go away?	< 2mts 1 2-5 mts 2 6-10 mts 3 >10 mts 4	
m. Have you ever had a severe pain or discomfort in the front of your chest lasting for half an hour or more?	Yes 1 No 2	**"2", go to the next section**
n. If ***'YES',*** was the pain or discomfort accompanied by - ***[Yes=1; No=2]***	Cold clammy skin Breathing difficulty Sweating	
o. How old were you when you had such a severe pain in the chest?	Years	
p. How many of these attacks have you had?		
q. Have you ever had an ECG done?	Yes 1 No 2	
r. Did you see a doctor because of the pain?	Yes 1 No 2	

II. PERIPHERAL VASCULAR DISEASE		
a. Do you get pain in either leg on walking?	Yes 1 No 2	**"2" go to the Part III**
b. If **YES**, in what part of your leg do you feel it?	Pain includes calf / calves 1 Pain does not include calf/claves 2	**"2" go to the Part III**
c. Do you get it if you climb stairs or walking fast?	Yes 1 No 2 Not Applicable 3	**"2" go to the Part III**
d. Do you get it if you walk at an ordinary pace on the level ground?	Yes 1 No 2	
e. Does the pain ever disappear while you are still walking?	Yes 1 No 2	**"1" go to the Part III**
f. What do you do if you get it when you are walking?	Stop or slacken pace 1 carry on 2	**"2" go to the Part III**
g. What happens to it if you stand still?	Relieved 1 Not Relieved 2	**"2" go to the Part III**
h. If relieved, how soon?	10 minutes or less 1 more than 10 minutes 2	
III. HEART FAILURE		
a. Are you unable to walk due to physical disability?	Yes 1 No 2	**"1" skip to Q. e**
b. Do you ever get short of breath while walking with other people of your own age on level ground?	Yes 1 No 2	
c. On walking uphill or upstairs, do you get more breathless than people of your own age?	Yes 1 No 2	**"2" go to Q. e**
d. Do you ever have to stop walking because of breathlessness?	Yes 1 No 2	
e. In the past years have you at any time awoken at night by an attack of shortness of breath?	Yes 1 No 2	**"2" go to Q. g**

f.	For how long have you had this problem?	Less than one year 1 More than one year 2	
g.	Do you have swelling in your ankles?	Yes 1 No 2	
h.	Have you been told by your doctor at any time that you are suffering from any lung disease (COPD, Asthma,etc)?	Yes 1 No 2	
i.	Do you have a cardiac device?	Yes 1 No 2	
j.	If "**YES**", name the device	Standard pacemaker 1 Implantable Cardioverter defibrillator (ICD) 2 Cardiac resynchronisation therapy device with defibrillator (CRT-D) 3	

PART - D: COMPLICATIONS

Complete the following sections only if you have filled the "diabetes section" (2) in PART-B

I. FOOT ULCERS AND AMPUTATION

a.	Have you ever had a non healing ulcer/sore in the foot that took more than 4 weeks to heal?	Yes 1 No 2	
b.	Do you walk around bare foot?	Yes 1 No 2	
c.	Have you had an amputation?	Yes 1 No 2	**"2" go to Part II**
d.	If '**YES'** When?	years before (or) months before	
e.	Level of amputation	Toe 1 Below ankle 2 Below knee 3 Above Knee 4	
f.	What was the cause for amputation?	Injury 1 Diabetes 2 Infection 3 Other 4	Others specify _____
g.	Do you have medical records or prescriptions?	Yes 1 No 2 Don't Know 3	

h. If the answer is '**YES'**, ask the participant to show the medical records and note the *diagnosis below*

II. EYES			
a.	Do you have difficulty with your eyesight other than your ordinary power glasses (spectacles)?	Yes 1 No 2	**"2" skip the section**
b.	If '**YES'**, were you told that your poor eyesight is due to complications of diabetes?	Yes 1 No 2	**"2" skip the section**
c.	If '**YES'**, what was the diagnosis?		
d.	Have you undergone laser therapy (Photocoagulation) at anytime	Yes 1 No 2	
e.	Do you have medical records or prescriptions?	Yes 1 No 2 Don't know 3	
f.	If the answer is **YES**, ask the participant to show the medical records and note the diagnosis below		

PART – E: RESPIRATORY DISEASE			
1.	In the past 12 months, have you had chronic **cough** and chronic mucous production on **most** days or nights of the week (during at least three months in a row)? ***[Yes=1; No=2]*** **Cough** means cough even when you are not suffering from cold **Most** means at least 4 days or nights per week		
	a. If '**YES'**	i. How many episodes of such cough have you had in the past 12 months?	
		ii. Have you suffered from any infections that required medical attention in the past 12 months? ***[Yes=1; No=2]***	
		iii. How many times did you seek medical attention in the past 12 months?	
2.	Have you seen a doctor or health practitioner for a chest infection (excluding TB) in the past 12 months? ***[Yes=1; No=2]***		
	a. If '**YES'**	i. How many episodes in the past 12 months?	
		ii. How many were doctor-diagnosed?	
		iii. For how long have you had such infection?	Yrs Mnts
		iv. Did you take antibiotics for these infections? ***[Yes=1; No=2; Don't know=3]***	
3.	Have you been hospitalized for a chest infection/pneumonia in the past 12 months? ***[Yes=1; No=2]***		
	a. If '**YES',** Length of stay		days weeks months

4. Do you currently suffer from asthma? ***[Yes=1; No=2]***	
a. IF '**YES**' i. How many attacks of asthma have you had in the past 12 months?	
ii. Have you suffered from any infections that required medical attention in the past 12 months? ***[Yes=1; No=2]***	
iii. How many times did you seek medical attention in the past 12 months?	
5. Have you ever been diagnosed with TB in past 5 years? ***[Yes=1; No=2; Don't remember=3]***	

PART – F: FAMILY HISTORY

1. Has anyone in your family suffered from any of the following diseases, **before the age of 60 years**? ***[Yes=1; No=2; Don't know=3]***	High blood pressure Heart disease* Diabetes mellitus (High Blood Sugar) Stroke (paralytic attack) ****Angina/ heart attack/heart failure***	

2. Fill the table below

Relationship to the family member	**Disease condition (refer to the codes below)***	**Age at diagnosis (in years)**	**If dead, age at which the family member died**
Father			
Mother			
Son			
Daughter			
Paternal Grandfather			
Paternal Grandmother			
Maternal Grandfather			
Maternal Grandmother			
Brother			
Sister			
Paternal uncle			
Paternal aunt			
Maternal uncle			
Maternal aunt			
For others, please write the relationship to the participant and provide the required details below			

****Disease condition: Diabetes = 1, heart disease = 2, high blood pressure = 3, Stroke = 4***

SECTION – 6: TREATMENT HISTORY AND EXPENDITURES

PART A: OUTPATIENT

1. Are you undergoing treatment as an out-patient for any of the following reasons? ***[Yes=1; No=2]***	Heart disease Stroke Diabetes Diabetic complications (infections, retinopathy, nephropathy, etc.) High blood pressure Chronic Kidney disease	

*If the answer to any of the above is **"YES"** go to the next section **OTHERWISE** skip to PART B*

In the following questions ask the details of treatment and cost only for the last 12 months

2. How many times did do you visit a health facility/doctor/therapist in past 12 month?		
3. Type of health facility/doctor/therapist	Government 1 Private 2 Charity 3 Others 4	***Others, specify*** _____

4. List the expenditures incurred towards the above mentioned conditions (Q.1) separately in each table

4.i. Disease _____

Nature of expenditure	Frequency	Amount spent in Rs per visit/ test/remuneration to home nurse or carer
Visit to Doctor (fees)		
No. of months home nurse / carer was hired		
Tests		
Physical or occupational rehabilitation		
Others (Specify)_____		
Medications ***(average amount spent in last 12 months for the above mentioned condition)***		
Total expenditure in past 12 months		

4.ii. Disease _____

Nature of expenditure	Frequency	Amount spent in RS per visit / test/remuneration to home nurse or carer
Visit to Doctor (fees)		
No. of months home nurse / career was hired		
Tests		
Physical or occupational rehabilitation		
Others (Specify)_____		
Medications ***(average amount spent in last 12 months for the above mentioned condition)***		
Total expenditure in past 12 months		

4.iii. Disease _____

Nature of expenditure	Frequency	Amount spent in RS per visit/ test/remuneration to home nurse or carer
Visit to Doctor (fees)		
No. of months home nurse / career was hired		
Tests		
Physical or occupational rehabilitation		
Others (Specify)_____		
Medications ***(average amount spent in last 12 months for the above mentioned condition)***		
Total expenditure in past 12 months		

4.iv. Disease _____

Nature of expenditure	Frequency	Amount spent in RS per visit/ test/remuneration to home nurse or carer
Visit to Doctor (fees)		
No. of months home nurse / career was hired		
Tests		
Physical or occupational rehabilitation		
Others (Specify)_____		
Medications ***(average amount spent in last 12 months for the above mentioned condition)***		
Total expenditure in past 12 months		

5. Did you get any reimbursement from insurance?	Yes 1 No 2 Don't know 3 Don't have any insurance 4	
6. If **YES**, of the above mentioned expenditure how much was reimbursed (in RS)?	RS _____	
7. Time taken to reach the health facility/doctor/therapist?	HR : MIN	
8. Transport cost to visit the above mentioned health facility/doctor/therapist*	RS _____	
If the participant has a private vehicle, ask him to give you an estimate of the amount spent on fuel to travel		
9. Average time spent at health facility	HR : MIN	
10. Are you getting proper medical attention? ***[Yes=1; No=2]***		
10.a. If **"No"** What has prevented you from getting medical attention?	Not available 1 No one to help me get there 2 Too far 3 Too expensive 4 Don't want to spend money 5 Complicated procedures for care seeking 6 Too long a wait 7 Too sick to make the trip 8 Do not trust medical care 9 Do not know where to go 10 Others (Specify) 11	If other, specify _____
11. How did you pay for your treatment and visits? ***[Yes=1; No=2]***	Own saving Family members paid Employer paid Borrowed from friend, relatives & employer Borrowed from bank Sold house, land or other assets Health insurance Others (specify)_____	
12. On an average what proportion of money in percentage (%) did you spent from the above mentioned source for your treatment and visits?	Own saving Family members paid Employer paid Borrowed from friend, relatives & employer Borrowed from bank Sold house, land or other assets Health insurance Others (Specify)_____	_____% _____% _____% _____% _____% _____% _____% _____%

Participant ID

PART B: INPATIENT		
1. Were you hospitalized for any illness in the **past 12 months**?	Yes 1 No 2 Don't remember 3	**"2 & 3" go to Q.4**
2. If **YES**, how many times?		
3. Were you admitted for any of the following reasons? ***[Yes=1; No=2]***	Heart disease Stroke Diabetes Diabetic complications (infections, retinopathy, nephropathy, etc.) High blood pressure Chronic Kidney disease	
4. Have you undergone any surgical procedure in the **past 12 months**?	Yes 1 No 2 Don't remember 3	**"2 & 3" go to Q.6**
5. If yes, what was the procedure? ***[Yes=1; No=2]***	Revascularisation / bypass Valve repair/replacement Pacemaker Amputation Abscess Renal transplantation Heart transplant Retinal photocoagulation Others (Specify_____)	
6. Do you have medical records related to hospitalization / surgical procedure?	Yes 1 No 2	

*If the answer is **YES,** ask the participant to show the medical records and note the diagnosis in a chronological order separately for hospitalisation due to illness and surgical procedures mentioned above in the space provided below*

Hospitalisation

Surgical procedure

Comments

PART C: HOSPITALISATION COST

Fill this section only if the participant has undergone hospitalisation due to illness or procedure mentioned in question 3 and 5 of part B, otherwise end the interview and thank the participant.

For each hospitalisation note the following details, starting with the first hospitalisation in past 12 months. If the number of hospitalisation is more than three then use a second form to complete the history.

Sl. No	Questions	1	2	3
1	When were you hospitalized?	MM YYYY	MM YYYY	MM YYYY
2	How many days did you stay in the hospital?	Days	Days	Days
3	Type of hospital? ***[Yes=1; No=2]***	Government Private Charity Other	Government Private Charity Other	Government Private Charity Other
4	Name of hospital (Address)			

Participant ID ☐☐☐☐☐

5	What type of treatment/procedure/ surgery did you undergo? ***(Cross-check with the medical records and information in PART-A)*** ***[Yes=1; No=2]***	Medicines ☐ Thrombolysis ☐ Angiogram ☐ Angioplasty ☐ Bypass surgery ☐ Brachytherapy ☐ Pacemaker ☐ Heart transplant ☐ Amputation ☐ Echocardiography ☐ Neuro-imaging ☐ Dialysis ☐ Kidney-transplant ☐ For observation ☐ Other procedure ☐ Specify ___________	Medicines ☐ Thrombolysis ☐ Angiogram ☐ Angioplasty ☐ Bypass surgery ☐ Brachytherapy ☐ Pacemaker ☐ Heart transplant ☐ Amputation ☐ Echocardiography ☐ Neuro-imaging ☐ Dialysis ☐ Kidney-transplant ☐ For observation ☐ Other procedure ☐ Specify ___________	Medicines ☐ Thrombolysis ☐ Angiogram ☐ Angioplasty ☐ Bypass surgery ☐ Brachytherapy ☐ Pacemaker ☐ Heart transplant ☐ Amputation ☐ Echocardiography ☐ Neuro-imaging ☐ Dialysis ☐ Kidney-transplant ☐ For observation ☐ Other procedure ☐ Specify _________
6	Total amount spent on treatment (hospitalisation expenses + medicines purchased during the stay)	Rs ________________	Rs ________________	Rs ________________
7	Number of days attendant stayed with you in the hospital	Days ☐☐	Days ☐☐	Days ☐☐
8	Cost of attendant's stay (include food accommodation and travel)	Rs _______________	Rs ____________	Rs ____________
9	Distance from home to hospital?	Kms ☐☐☐	Kms ☐☐☐	Kms ☐☐☐
10	Cost of travel from home to hospital (excluding ambulance cost, if any)	Rs __________________	Rs __________________	Rs __________________

11	What type of medical insurance do you have? ***[Yes=1; No=2]***	Free medical treatment Commercial Insurance None Self-pay Other (________________) Specify	Free medical treatment Commercial Insurance None Self-pay Other (________________) Specify	Free medical treatment Commercial Insurance None Self-pay Other (____________) Specify
12	Amount reimbursed from health insurance, if any?	Rs ___________________	Rs ___________________	Rs ___________________
13	How do you pay for your hospitalisation costs? ***[Yes=1; No=2]***	Own saving Family members paid Employer paid Borrowed from friends , relatives, employer Borrowed from bank Sold house, land, or other assets Health insurance Other (Specify___________)	Own saving Family members paid Employer paid Borrowed from friends , relatives, employer Borrowed from bank Sold house, land, or other assets Health insurance Other (Specify___________)	Own saving Family members paid Employer paid Borrowed from friends , relatives, employer Borrowed from bank Sold house, land, or other assets Health insurance Other (Specify___________)
14	Proportion of money in percentage (%) did you spent from the above mentioned source for your hospitalisation?	Own savings____________% Family members paid__________________% Employer paid__________% Borrowed from friends, relatives, employer ______% Borrowed from bank _____% Sold house, land, or other assets _________________% Health insurance________% Other _________________% (Specify ___________)	Own savings____________% Family members paid__________________% Employer paid__________% Borrowed from friends, relatives, employer ______% Borrowed from bank _____% Sold house, land, or other assets _________________% Health insurance________% Other _________________% (Specify ___________)	Own savings___________% Family members paid_________________% Employer paid_________% Borrowed from friends, relatives, employer _____% Borrowed from bank ____% Sold house, land, or other assets ________________% Health insurance_______% Other ________________% (Specify ___________)

15. Time interview ended: __ __ : __ __
HR MIN