Updated Jan 20, 2023

PRECISION-CARRS

Study Questionnaire

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PRECISION-CARRS | *Main Study Questionnaire*

Participant ID	☐☐☐☐☐☐	**Household ID**	☐☐☐☐☐☐
CEB Code	☐☐☐	**Date of interview** (DD/MM/YY)	☐☐☐☐☐☐
Centre Code	☐	**Cohort**	☐
Interviewer ID	☐☐☐☐		

SECTION 1: RESPONSE AND CONTACT INFORMATION

PART 1A: RESPONSE OF THE PARTICIPANT

1. Does the participant agree to be interviewed?	Yes$_1$ No$_2$	☐ If yes, skip to Part 1B
1a. If the participant does not agree to be interview what is the reason?	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 follow-up$_7$ Other$_{777}$ _____	☐ If "**Other**"- please specify in detail: _____ _____

If the answer in above question is 2, 4, 5 or 7 - complete the next question.

If the answer in above question is 6 - skip this questionnaire and please complete the **Verbal Autopsy Form (Appendix C1).**

2. If participant refused to be interviewed what is the reason?	Not able to give time$_1$ Interviews are lengthy$_2$ Not interested in providing blood samples$_3$ Too much blood drawn$_4$ Not satisfied with the lab report$_5$ Need more medical attention/medicines$_6$ Do not see any benefit in participating in the study$_7$ Do not feel secure$_8$ Do not want to give any reason$_9$ Others$_{777}$	☐ ☐ ☐ If "**Other"** please specify in detail: _____ _____

PART 1B: PARTICIPANT INFORMATION

1. Name of the Participant	_____	
2. Age (in completed years)		☐☐☐
3. Father's name	_____	
4. Mother's name	_____	

PART 1C: CONTACT DETAILS		
1. Email-ID		
2. Mobile number-1 (self-new or current)		
3. Mobile number-2 (self-new or current)		
4. Does the participant have Aadhar card?	Yes$_1$ No$_2$ Yes, refused to provide $_3$	☐
4a. **If "Yes" -** Aadhar Number ***NOTE**: Aadhar card information is not mandatory*	☐☐☐☐☐☐☐☐☐☐☐☐	
5. What is the present address?	Same as last follow-up$_1$ Changed$_2$	☐ If "1" skip to Q6
5a. If changed, note the current address House Number Street District State Pin Code Nearby landmark		
6. Name of the 1st contact person		
6a. Relationship with the participant		
6b. Address of the 1st contact person		
6c. Mobile number of 1st contact person		
7. Name of the 2nd contact person		
7a. Relationship with the participant		
7b. Address of the 2nd contact person		
7c. Mobile number of 2nd contact person		

SECTION 2: MEDICAL HISTORY

PART 2A: CARDIOVASCULAR HISTORY

*(**NOTE**: If response is auto-populated as Yes or answers to any of the below question is "**Yes**" - **Detailed Event Form (Appendix B)** will be filled. The detailed event form will contain modules to collect: records/documents, symptoms, and any tests, treatments, length of stay)*

In the past, you have indicated a history of having auto-populate.

1. Since our last visit with you in year auto-populate, have you been diagnosed with or has a doctor or other health professional ever told you that you have? ***(Since the last interview)*** *For each of these, we need to open module to gather more information:* *Availability of medical records:* ***If "Yes"** - take copies* ***If "No"** - more questions:* - *Date* - *Symptoms* - *Place they went (clinic, hospital, naturopath, home)* - *Tests they remember* - *Procedures they remember* - *Days treated or stayed in hospital*				**If "YES"** - when was it diagnosed (since the last interview)?
	1a. Heart attack or myocardial infarction	Yes$_1$ No$_2$ Don't know$_{999}$	☐	☐☐ ☐☐ Month / Year
	1b. Angina	Yes$_1$ No$_2$ Don't know$_{999}$	☐ **If"2" or "999"**- go to 1c	☐☐ ☐☐ Month / Year
	1b (i) If "Yes" – Over the past 4 weeks, on average, how many times have you had chest pain, chest tightness, or angina?	4+/day – 1 1-3/day – 2 3/week – 3 1-2/week – 4 <1/week – 5 none over past 4 weeks – 6	☐ If "6", skip to Q1c	
	1b (ii) Over the past 4 weeks, on average, how many times have you had to nitroglycerin (tablets under your tongue or spray) for your chest pain, tightness, or angina?	4+/day – 1 1-3/day – 2 3/week – 3 1-2/week – 4 <1/week – 5 none over past 4 weeks – 6	☐	
			If "YES" – when was it diagnosed (since the last interview)?	
	1c. Heart failure	Yes$_1$ No$_2$ Don't know$_{999}$	☐	☐☐ ☐☐ Month / Year
	1d. Physician-diagnosed irregular heart rhythm	Yes$_1$ No$_2$ Don't know$_{999}$	☐	☐☐ ☐☐ Month / Year
	1e. Stroke	Yes$_1$ No$_2$ Don't know$_{999}$	☐ **If"2" or "999",** go to 1f	☐☐ ☐☐ Month / Year

	1e (i)If "Yes" – did person: 1. receive physical therapy? 2. receive speech therapy 3. any residual weakness / paralysis of arms, legs, or side? 4. Any residual speech concerns? 5. Any surgical procedure for stroke: (Craniotomy for decompression or stenting of cranial vessels)	**Yes=1, No=2** ☐ ☐ ☐ ☐ ☐		
	1f. Peripheral vascular disease (claudication, ischemic rest pain)— **Prompt:** Do you have pain or cramping ***(not due to arthritis)*** in your calf muscle (knee to ankle joint) when walking that is relieved by resting?	Yes$_1$ No$_2$ Don't know$_{999}$	☐	☐☐ ☐☐ Month / Year
2. Since our last visit with you, have you had any of the following procedures or therapies?	2a. Balloon angioplasty of your heart blood vessels (procedure to open up or stent blood vessels of heart)?	Yes$_1$ No$_2$ Don't know$_{999}$	☐	☐☐ ☐☐ Month / Year
	2b. Open-heart surgery (coronary bypass surgery)?	Yes$_1$ No$_2$ Don't know$_{999}$	☐	☐☐ ☐☐ Month / Year
	2c. Procedure to open up or stent blood vessels in arms or legs?	Yes$_1$ No$_2$ Don't know$_{999}$	☐	☐☐ ☐☐ Month / Year
				3a. If yes, since the last visit, when was it amputated
3. Have you had an amputation of the lower limb?	Yes$_1$ No$_2$		☐	☐☐ ☐☐ Month / Year
If "2" for Q3, skip to Q4 (Functional status), if "1" for Q3, go to Q3a				
3b. What was the level of amputation?	Toe$_1$ Forefoot$_2$ Ankle$_3$ Below knee$_4$ Above knee$_5$		☐	
3c. What was the cause for the most recent amputation?	Injury$_1$ Diabetes$_2$ Infection$_3$ Diabetes and Injury$_4$ Diabetes and infection$_5$ Other$_{777}$		☐ If other, please specify _____	

Functional Status			
4. Please select an option which best summarizes your ability to do physical activities.	1) I can perform all physical activity without getting short of breath or tired, or having palpitations 2) I get short of breath or tired, or have palpitations when performing more strenuous activities. For example, walking on steep inclines or walking up several flights of steps 3) I get short of breath or tired or have palpitations when performing day-to-day activities. For example, walking on a flat surface 4) I feel breathless at rest and am mostly housebound. I am unable to carry out any physical activity without getting short of breath or tired or having palpitations	1 2 3 4	☐

PART 2B: CARDIO METABOLIC DISEASES AND THEIR RISK FACTORS

In the past, you have indicated a history of having auto-populate.

		1a. Hypertension (High Blood Pressure)	1b. Diabetes (High Blood Sugar)	1c. Hyperlipidemia (High Blood Cholesterol or Triglycerides)
1. If no prior history, since our last interview, have you been told by a doctor that you have any of the following diseases? (*Since the last interview*)	Yes 1 No 2 Don't know 999	☐	☐	☐
If "2" or "999" for Q1- skip to part 2C (Cancer)				
1d. If "YES" - since how many years have you had any of the following diseases: Hypertension/ Diabetes/ Hyperlipidemia?	YEAR MONTH	☐☐ ☐☐	☐☐ ☐☐	☐☐ ☐☐
2. For your health, are you following/taking any of these treatments?				
2a. Allopathic drugs (English/modern)	Yes 1 No 2	☐	☐	☐
If "YES" – complete **Medication Documentation** process.				
2b. Prescribed dietary modification	Yes 1 No 2	☐	☐	☐
2c. Prescribed physical exercise	Yes 1 No 2	☐	☐	☐
2d. Traditional medicine/Therapy* other than yoga	Yes 1 No 2	☐	☐	☐
	Yes 1 No 2	☐	☐	☐

2e. Yoga or Meditation				

**Traditional medicine/therapy include Ayurveda, Unani, Homeopathy, Tibetan, Naturopathy*

PART 2C: CANCER

1. Since our last visit with you in _____, have you been told by a doctor that you have cancer? *(Since the last interview)*		Yes$_1$ No$_2$ Don't know$_{999}$	☐ **If "2**" or "**999**" - Skip to Part 2D (kidney disease)

1a. If "Yes" - which site?		1b. How was it detected?	1c.At what stage it was diagnosed?	1d.When were you diagnosed with it? *(Year of diagnosis)*
Site 1	☐	☐	☐	☐☐☐☐
Site 2	☐	☐	☐	☐☐☐☐
Site 3	☐	☐	☐	☐☐☐☐
Site 4	☐	☐	☐	☐☐☐☐
Site 5	☐	☐	☐	☐☐☐☐
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$_{13}$; Uterine cancer$_{14}$; Head or neck cancer$_{15}$; Blood cancer$_{16}$; cancer of lymph nodes$_{17}$; Skin cancer$_{18}$; Others$_{999}$; Unknown$_{20}$ Note:For Female participants only breast/cervix/ovary/uterus		Participant had symptoms$_1$ At routine check-up or screening$_2$ Not sure/Don't Know$_{999}$	Stage0/in situ stage I $_1$ StageI$_2$ StageII$_3$ Stage III$_4$ Stage IV$_5$ Don't know$_{999}$	

2. **If "Yes"** - what treatments did you receive (multiple choice)? **Yes$_1$; No$_2$; Don't know$_{999}$**

2a. Surgery	☐
2b. Hormone therapy	☐
2c. Radiotherapy (X-ray for treatment)	☐
2d. Chemotherapy (cancer cell killing drugs)	☐
2e. Palliative treatment (treatment to relieve pain)	☐
2f. Non-allopathic (Ayurvedic/ Homeopathic/ traditional)	☐

PART 2D: KIDNEY DISEASE

1. Since our last visit with you in _____, have you been told by a doctor that you have kidney disease? *(Since the last interview)*	1a. Kidney stone	Yes$_1$ No$_2$ Don't know$_{999}$	☐
	1b. Kidney disease	Yes$_1$ No$_2$ Don't know$_{999}$	☐
	1c. Kidney failure	Yes$_1$ No$_2$ Don't know$_{999}$	☐

If "Yes" for kidney disease, kidney stone or kidney failure go to Q2:
If "2" or "999" skip to Q4

2. Since our last visit with you, have you seen a kidney doctor or a nephrologist?		Yes$_1$ No$_2$ Don't remember$_{666}$ Don't know$_{999}$	☐
3. Have you ever undergone the following tests?	3a Urine test to check for protein leak	Yes$_1$ No$_2$ Don't remember$_{666}$ Don't know$_{999}$	☐
	3b Kidney ultrasound	Yes$_1$ No$_2$ Don't remember$_{666}$ Don't know$_{999}$	☐
	3c Kidney biopsy	Yes$_1$ No$_2$ Don't remember$_{666}$ Don't know$_{999}$	☐
4. Are you currently undergoing maintenance dialysis?		Yes$_1$ No$_2$	☐ If "2", skip to Q5
4a. If "Yes" - date of dialysis initiation:		☐☐ Day ☐☐ Month ☐☐☐☐ Year	
5. Have you ever undergone kidney transplant?		Yes$_1$ No$_2$	☐ If "2", skip to section 3
5a. If "Yes" - date of kidney transplant:		☐☐ Day ☐☐ Month ☐☐☐☐ Year	

SECTION 3: TREATMENT HISTORY

PART 3A: OUTPATIENT

1. Are you undergoing treatment as an outpatient? (In the past 1 year)	Yes$_1$ No$_2$	☐ **If the answer is "Yes"** - go to the next question. **Otherwise** - skip to part 3B
2. Are you undergoing treatment as an outpatient for any of the following reasons? (In the past 1 year) Yes$_1$ No$_2$	Heart disease Stroke Diabetes Diabetic complications (*infections, Retinopathy, Nephropathy, etc.*) High blood pressure Chronic Kidney disease Cancer Other If other, specify _____	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ **If the answer to any of the box is "Yes"** - go to the next question. **Otherwise** - skip to part 3B
***NOTE**: The following questions ask the details of treatment only for the last 12 months.*		
3. How many times did do you visit a health facility/doctor/therapist in past 12 month?		☐☐
4. Type of health facility/doctor/therapist	Government$_1$ Private$_2$	☐ ☐

(Multiple choice)	Charity$_3$ Others$_4$	
PART 3B: INPATIENT		
1. Did you go to a hospital emergency room in the past 12 months?	Yes$_1$ No$_2$ Don't remember $_{666}$	☐ **If "2" or "666"** - skip to Q2
1a. If "Yes" - how many times?	☐☐	
2. Were you kept in the hospital for <u>observation</u> for any illness in the past 12 months? *(e.g., Admitted in morning and discharged by evening)*	Yes$_1$ No$_2$ Don't remember $_{666}$	☐ If "2" or "666", skip to Q3
2a. If "Yes" - how many times?	☐☐	
3. Were you <u>hospitalized</u> for any illness in the past 12 months? *(Admitted for overnight stay or >24 hours)*	Yes$_1$ No$_2$ Don't remember $_{666}$	☐ If "2" or "666", skip to Q4
3a. If "Yes" - how many times?	☐☐	
3b. 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 Cancer Other If "**Other"** please specify: _____	☐ Length of stay: _____ days ☐ Length of stay: _____ days ☐ Length of stay: _____ days ☐ Length of stay: _____ days ☐ Length of stay: _____ days ☐ Length of stay: _____ days ☐ Length of stay: _____ days ☐ Length of stay: _____ days
4. Do you have medical records related to hospitalization?	Yes$_1$ No$_2$ Yes, refused to provide $_3$ Not applicable $_{555}$	☐ If "2", "3" or "555", skip to section 4
5. **If "Yes**" - ask the participant to show the medical records and note the diagnosis in a chronological order separately for hospitalization due to illness and surgical procedures mentioned above in the space provided below.		
Hospitalization:		

Surgical procedure:
Comments:

SECTION 4: EYES		
1. Since our last visit with you, have you ever seen a doctor for difficulty with your eyesight other than your ordinary power glasses (spectacles)?	Yes$_1$ No$_2$	☐ **If "2"** - skip to section 5.
2. Since our last visit with you in auto-populate, has an eye doctor ever told you that you have:	Cataract$_1$ Retinopathy$_2$ Both (cataract & retinopathy)$_3$ Other$_{777}$	☐ **If "1**" – skip to section 5. If "**Other"** please specify: _____
3. **If** selected **"r**etinopathy" or "both (cataract & retinopathy)" for question 2, what was the cause for the retinopathy?	Hypertension$_1$ Diabetes$_2$ Both (hypertension & diabetes)$_3$ Other$_{777}$ _____	☐ If "**Other"** please specify: _____
4. If selected "retinopathy" or "both (cataract & retinopathy)" for question 2, when was the retinopathy diagnosed?	☐☐ Month ☐☐☐☐ Year	
5. Since our last visit with you in auto-populate, have you undergone laser therapy (Photocoagulation) anytime?	Yes$_1$ No$_2$	☐
5a. If "Yes" for laser therapy (Photocoagulation), when?	☐☐ Month ☐☐☐☐ Year	

SECTION 5: COVID-19		
1. Have you experienced COVID-19 disease, the condition caused by SARS-CoV-2 infection, since March 2020?	Yes$_1$ No$_2$ Don't know$_{999}$	☐ **If "2" or "999"** – skip to Q5.
1a. If yes, how was it diagnosed? *(Multiple choice)*	Home COVID-19 antigen test$_1$ RT-PCR$_2$ No test, just symptoms$_3$	☐
2. How many episodes/events of the infection did you experience? *(Gap of 21 days between two episodes)*	Number of episodes/ events of the COVID-19 infection	☐☐
3. Were you hospitalised for COVID-19 disease?	Yes$_1$ No$_2$	☐

4. Have you experienced long COVID-19 symptoms (fatigue, brain fog, loss of smell, joint pain etc)?	Yes$_1$ No$_2$	☐
5. Have you taken the COVID-19 vaccination?	Yes$_1$ No$_2$	☐ **If "2"** – skip to section-6
5a. How many doses have you received?	First Dose-1 Second Dose-2	☐
5b. Name of the vaccine taken:	Covaxin$_1$ Covishield$_2$ Sputnik$_3$ Others$_{777}$	☐ **If "Other"**- please specify: _____
6. Have you taken Precautionary (i.e., booster) dose?	Yes$_1$ No$_2$	☐ **If "2"** – skip to section-6
6a. Name of the booster vaccine taken:	Covaxin$_1$ Covishield$_2$ Sputnik$_3$ Others$_{777}$	☐ **If "Other"**- please specify: _____

SECTION 6: TOBACCO USE, ALCOHOL USE, DIET, PHYSICAL ACTIVITY, AND SLEEP DETAILS

PART 6A: TOBACCO USE

1. Have you **EVER** used tobacco in any form (smoking, chewing, snuff, etc.)?	Yes$_1$ No$_2$	☐ **If "2"** – skip to Part 6B (Alcohol Use).
2. If "Yes" – in what forms have you EVER consumed tobacco?		
2a. Smoking form	Yes$_1$ No$_2$	☐
2b. Chewed form	Yes$_1$ No$_2$	☐
2c. Any other form	Yes$_1$ No$_2$	☐
3. Do you **currently*** consume tobacco? (**Currently means in last 6 months*)	Yes$_1$ No$_2$	☐ **If "2"** – skip to Q6.
4. If "Yes" – what type?		
4a. Smoking form	Yes$_1$ No$_2$	☐
4b. Chewed form	Yes$_1$ No$_2$	☐
4c. Any other form	Yes$_1$ No$_2$	☐
5. If smoking forms, how many packs/numbers per day?	_____ (packs per day) **OR** _____ (numbers per day)	
6. At what age did you first start smoking regularly?	Don't remember$_{666}$	☐☐
7. At what age did you first start consuming smokeless tobacco product regularly?	Don't remember$_{666}$	☐☐

PART 6B: ALCOHOL USE		
1. Have you EVER consumed alcohol?	Yes 1 No 2	☐ **If "2"** – skip to Part 6C.
2. If yes, how often did you have a drink containing alcohol in the past year?	Never$_1$ Monthly or less$_2$ Two to four times a month$_3$ Two to three times a week$_4$ Four or more times a week$_5$	☐ **If "1"** – skip to Part 6C.
3. How many drinks containing alcohol did you have on a typical day when you were drinking in the past year? *1 standard drink of Beer: 360 ml* *1 standard drink of Wine: 150 ml* *1 standard drink of Spirit: 45 ml*	1 or 2 drinks$_1$ 3 or 4$_2$ 5 or 6$_3$ 7 to 9$_4$ 10 or more$_5$	☐
4. How often did you have four or more drinks on one occasion in the past year?	Never$_1$ Less than monthly$_2$ Monthly$_3$ Weekly$_4$ Daily or almost daily$_5$	☐
PART 6C: DIET		
1. In a typical week, on how many days do you eat fruit?	Number of days (in a week) Don't remember$_{666}$	☐ **If "0"** – skip to Q2
1a. How many servings of fruit do you eat on one of those days?	Number of servings Don't remember$_{666}$	☐
2. In a typical week, on how many days do you eat vegetables?	Number of days Don't remember$_{666}$	☐ **If "0"** – skip to Part 6D.
2a. How many servings of vegetables do you eat on one of those days?	Number of servings Don't remember$_{666}$	☐
PART 6D: PHYSICAL ACTIVITY		
1. How much time do you usually spend sitting or reclining on a **typical day**?	Hours: Minutes	☐☐ ☐☐
2. Do you undertake any **moderate** physical activities for a minimum of 150 minutes in a typical week? *This is physical activity that increases the heart rate, such as walking fast, climbing stairs, jogging, cycling, dancing, playing sports and games, yoga, carrying/moving moderate loads (<20kg), etc.*	Yes$_1$ No$_2$	☐
PART 6E: SLEEP DETAIL		
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 hours	On weekends: ☐☐ No. of hours

STOP questionnaire: A tool to screen patients for obstructive sleep apnea (OSA).		
2. **Snoring:** Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?	Yes$_1$ No$_2$ Don't know$_{999}$	☐
3. **Tired:** Do you often feel tired, fatigued, or sleepy during daytime?	Yes$_1$ No$_2$ Don't know$_{999}$	☐
4. **Observed**: Has anyone observed you stop breathing during your sleep?	Yes$_1$ No$_2$ Don't know$_{999}$	☐

SECTION 7: 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.	Have little interest or pleasure in doing things	Not at All$_1$ Several Days$_2$ More than half the days$_3$ Nearly every day$_4$	☐
2.	Feeling down, depressed, or hopeless	Not at All$_1$ Several Days$_2$ More than half the days$_3$ Nearly every day$_4$	☐
3.	Trouble falling or staying asleep or sleeping too much	Not at All$_1$ Several Days$_2$ More than half the days$_3$ Nearly every day$_4$	☐
4.	Feel tired or feel like having little energy	Not at All$_1$ Several Days$_2$ More than half the days$_3$ Nearly every day$_4$	☐
5.	Poor appetite or overeat	Not at All$_1$ Several Days$_2$ More than half the days$_3$ Nearly every day$_4$	☐
6.	Feeling bad about yourself – or that you are a failure or have let yourself or your family down	Not at All$_1$ Several Days$_2$ More than half the days$_3$ Nearly every day$_4$	☐
7.	Trouble concentrating on things, such as reading the newspaper or watching television	Not at All$_1$ Several Days$_2$ More than half the days$_3$ Nearly every day$_4$	☐

8.	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	Not at All$_1$ Several Days$_2$ More than half the days$_3$ Nearly every day$_4$	☐
9.	Thoughts that you be better off dead, or of hurting yourself in some way	Not at All$_1$ Several Days$_2$ More than half the days$_3$ Nearly every day$_4$	☐
10.	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	Not difficult at all$_1$ Somewhat difficult$_2$ Very difficult$_3$ Extremely difficult$_4$	☐

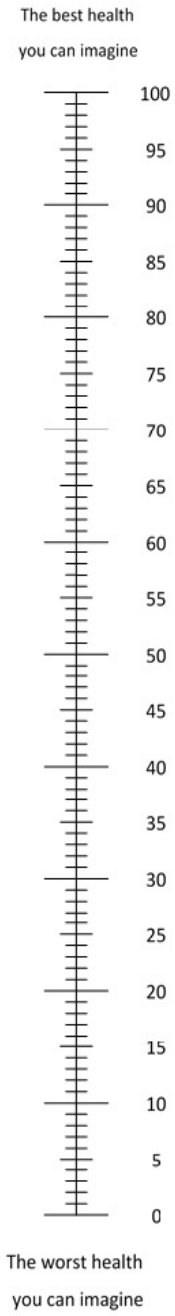
SECTION 8: QUALITY OF LIFE (EQ-5D-5L)

1.	Mobility	I have no problems in walking about$_1$ 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$_5$	☐
2.	Self- Care	I have no problems in bathing or dressing myself$_1$ 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$_5$	☐
3.	Usual Activities (e.g. work, study housework family or leisure activities)	I have no problems doing my usual activities$_1$ 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$_5$	☐
4.	Pain/ Discomfort	I have no pain or discomfort$_1$ 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$_5$	☐
5.	Anxiety/ Depression	I am not anxious or depressed$_1$ 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$_5$	☐

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 =	



SECTION 9: SOCIO-DEMOGRAPHIC & SOCIO-ECONOMIC STATUS		
PART 9A: DEMOGRAPHIC DETAILS		
1. What is your current marital status?	Single$_1$ Married$_2$ Widow/Widower$_3$ Separated/Divorced$_4$ Others$_{777}$	☐ If 1, Skip to Part 9B If "**Other**" please specify _____
1a. Spouse name		
1. Is your spouse enrolled in the CARRS study (i.e., the opposite sex participant)?	Yes$_1$ No$_2$	☐
Part 9B: SOCIO-ECONOMIC DETAILS		
1. What is your highest level of education attained? ** 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/postgraduate$_1$ Graduate (B.A/B.Sc./B. Com/Diploma)$_2$ Secondary School /Intermediary (ITI course, class X/XII or Intermediate) $_3$ High school (class V to IX)$_4$ Primary School (up to Class IV)$_5$ *****Literate, no formal education$_6$ ******Illiterate$_7$ Others$_{777}$ **If** "**Other**" - please specify: _____ _____ _____	☐ If "6" or "7", skip to Q3
2. What is your total number of years of schooling?		☐☐ Number of years
3. What is your total household income per month (INR)? ***NOTE**: Please include income from all members who contribute to the household* ***If they refuse or can't provide exact number, provide the ranges.***	3a. Total household income /month (INR) (exact income)	_____
	3b. <3000$_1$ 3001-10,000$_2$ 10,001-20,000$_3$ 20,001-30,000$_4$ 30,001-40,000$_5$ 40,001-50,000$_6$ 50,001 - 100,000$_7$ 1,00,001-1,50,000$_8$ >1,50,000$_9$ Refused to answer$_{888}$ Don't know$_{999}$	☐
4. Which of the following best describes your **main work** status over the past 12 months? Specify Occupation.	Government employee$_1$ Non-government employee$_2$ Self-employed$_3$ Non-paid$_4$ Student$_5$ Homemaker$_6$ Retired$_7$ Unemployed (able to work)$_8$ Unemployed (unable to work)$_9$	☐ Specify the occupation, if selected 1,2 or 3 _____

	Refused to answer$_{888}$ Don't Know$_{999}$	
5. Do you have a separate room for cooking (Kitchen)?	Yes$_1$ No$_2$	☐
6. What is the fuel used for cooking? ***NOTE**: 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/IGL$_2$ Wood/dung$_3$ Others$_{777}$ _____	☐ **If "Other"**- please specify: _____
7. What is the source of drinking water used at home?	Public source$_1$ Private source (Shared)$_2$ Private source (Own)$_3$ Bottled water$_4$ Purified tap water$_5$ Others$_{777}$	☐ **If "Other"**- please specify: _____
8. What is the toilet facility you use?	Public toilet$_1$ Shared toilet$_2$ Own flush toilet$_3$ Others$_{777}$	☐ **If "Other"**- please specify: _____

9. Which of the following do you own? Yes=1, No=2	
9a. Television	☐
9b. Refrigerator	☐
9c. Washing machine	☐
9d. Microwave/OTG	☐
9e. Mixer-grinder	☐
9f. Mobile phone / Tablet phones (iPad)	☐
9g. DVD player	☐
9h. Computer/Laptop	☐
9i. Car	☐
9j. Motorcycle/ Scooter	☐
9k. Bicycle	☐
9l. Dishwasher	☐

10. Do you have any domestic help for house chores, cooking, etc.?	Yes$_1$ No$_2$	☐

SECTION 10: FEMALE REPRODUCTIVE HISTORY (Only for Females)

***NOTE**: This section is to be filled only for the **female participants**. For **male participants**, go to section 11 (medical documents), if no medical documents are available end the questionnaire and thank the participant.*

1. Have you ever been pregnant?	Yes$_1$ No$_2$	☐ **If "2**" - skip to Q10.
2. How many live births have you had? *	_____ births 999 = don't know Not applicable$_{555}$	☐ If 555 skip to Q5
3. How old were you at your first live birth? *	_____ years 999 = don't know	
4. What is the date of birth of your youngest biological child? ***NOTE**: If the participant is unable to recall, skip to 4a*	☐☐ ☐☐ ☐☐ DD / MM / YY 999 = don't know	
4a. If the participant is unable to recall the exact date of birth of the youngest child, how old is your youngest child (age in completed years)?	☐☐ **Age** (in years)	
5. For women with a history of diabetes *** (auto-populate), did you have diabetes prior to any pregnancies?	Yes$_1$ No$_2$ Don't know $_{999}$ Not applicable$_{555}$	☐
6. Were you diagnosed to have gestational diabetes in any of the pregnancies? ***NOTE**: Gestational diabetes is diabetes that was newly detected during pregnancy.*	Yes$_1$ No$_2$ Don't know $_{999}$ Not applicable$_{555}$	☐
7. Did you receive any drug (insulin/metformin/ glibenclamide) for treatment of diabetes during pregnancy?	Yes$_1$ No$_2$ Don't know $_{999}$	☐
8. For women with a history of hypertension ***(auto-populate), did you have hypertension prior to any pregnancies?	Yes$_1$ No$_2$ Don't know $_{999}$ Not applicable$_{555}$	☐
9. Were you newly diagnosed to have hypertension in any of the pregnancies?	Yes$_1$ No$_2$ Don't know $_{999}$ Not applicable$_{555}$	☐
10. Do you know at what age you had your first menstrual period?	Yes$_1$ No$_2$	☐ If "2" go to Q11
10a. How old were you when you had your first menstrual period?	☐☐ Years	
11. Are you having menstrual cycles?	Yes $_1$ No$_2$	☐ **If "1"** - go to "Q13

11a. If "No" - what is the reason? ***NOTE**:* *Hysterectomy means removal of the uterus/womb with or without removal of the ovaries* *Natural menopause means no menstrual period for 1 year and no medical intervention.*	Pregnancy 1 Lactation2 Natural menopause3 Hysterectomy4 Others777	☐ **If "Others" (option 5)** – please specify: _____
12. If above question 11a is filled with 3, 4 or 777, do you know at what age did you stop menstruating?	Yes 1 No 2	☐ Is "1", go to Q12a If "2", go to Q12b
12a. At what age did you stop menstruating?	☐☐ **Age** (in years)	
12b If the participant cannot recall the date	☐☐ YY ☐☐ MM ☐☐ Ago	
13. Have you used hormonal medicines (that is, estrogen or progesterone combinations) for hormonal replacement therapy, to regulate your periods or for birth control? Yes1 No2	**Ever used in past** ☐	**Current** ☐
SECTION 11: MEDICINE DOCUMENTS (ALL THE PARTICIPANTS)		
1. Does the participant share any prescribed medicine records/documents?c	Yes 1 No2	☐ **If "1" check if all the ducments are scanned** **If "2", thank the partipant and end the questionnaire**

APPENDIX A.1 | *Sub-Study 1 – Risk/Time Preference*

NOTE: *Delhi and Chennai; 1 in 4 participants; need 3500 participants (1750/site)*

A Validated Instrument for Measuring Risk, Time, and Social Preferences

RISK PREFERENCE

We will be asking 3 questions now. In these questions, we will be talking about money. However, this is just for imagination, you will not be receiving money in reality. But answer these questions as though the situations were to really happen.

NOTE: *Each participant will be asked a total of three questions.*

1. We will now give you two options; please tell which option you would choose?	1) Definitely receiving Rs.320 2) A 50-50 chance of receiving Rs. 600	☐ If selected "1", go to Q 1a If selected "2", go to Q 1d
1a. We will now give you two options; please tell which option you would choose?	1) Definitely receiving Rs.160 2) A 50-50 chance of receiving Rs. 600	☐ If selected "1", go to Q 1b If selected "2", go to Q 1czz
1b. We will now give you two options; please tell which option you would choose?	1) Definitely receiving Rs.80 2) A 50-50 chance of receiving Rs. 600	☐
1c. We will now give you two options; please tell which option you would choose?	1) Definitely receiving Rs.240 2) A 50-50 chance of receiving Rs. 600	☐
1d. We will now give you two options; please tell which option you would choose?	1) Definitely receiving Rs.460 2) A 50-50 chance of receiving Rs. 600	☐ If selected "1", go to Q 1e If selected "2", go to Q 1f
1e. We will now give you two options; please tell which option you would choose?	1) Definitely receiving Rs.400 2) A 50-50 chance of receiving Rs. 600	☐
1f. We will now give you two options; please tell which option you would choose?	1) Definitely receiving Rs.540 2) A 50-50 chance of receiving Rs. 600	☐

TIME PREFERENCE

We will ask you 3 more questions like the previous questions, but this is slightly different. We will give you two options this time: In one option you can choose to receive a payment today and in the other option is to choose to receive a different amount in 12 months. We will now present to you 3 situations. For each of these situations we would like to know which you would choose. Please assume there is no inflation, i.e., future prices are the same as today's prices. Please remember that like the previous questions, this is only hypothetical, but answer these questions as though the situations were to really happen.

NOTE: *Each participant will be asked a total of three questions.*

2. We will now give you two options, please tell me which one you would choose:	1) Receiving Rs. 200 today 2) Receiving Rs. 308 after one year	☐ If selected "1", go to Q 2a If selected "2", go to Q 2d
2a. We will now give you two options, please tell me which one you would choose:	1) Receiving Rs. 200 today 2) Receiving Rs. 370 after one year	☐ If selected "1", go to Q 2b If selected "2", go to Q 2c
2b. We will now give you two options, please tell me which one you would choose:	1) Receiving Rs. 200 today 2) Receiving Rs. 403 after one year	☐
2c We will now give you two options, please tell me which one you would choose:	1) Receiving Rs. 200 today 2) Receiving Rs. 338 after one year	☐
2d. We will now give you two options, please tell me which one you would choose:	1) Receiving Rs. 200 today 2) Receiving Rs. 251 after one year	☐ If selected "1", go to Q 2e If selected "2", go to Q 2f
2e. We will now give you two options, please tell me which one you would choose:	1) Receiving Rs. 200 today 2) Receiving Rs. 278 after one year	☐
2f. We will now give you two options, please tell me which one you would choose:	1) Receiving Rs. 200 today 2) Receiving Rs. 225 after one year	☐

Time preference - One question measure	Don't know=999 Refused
1. Please tell me, in general, how willing or unwilling you are to take risks, using a scale from 0 to 10, where 0 means you are "completely unwilling to take risks" and 10 means you are "very willing to take risks." You can also use any number between 0 and 10 to indicate where you fall on the scale, using 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, or 10.	☐
2. How willing are you to give up something that is beneficial for you today in order to benefit more from that in the future? **0- Completely unwilling to do so;10- Very willing to do so**	☐
3. Please let me know how much you agree or disagree with the following statements on a scale of 0 - 10: **0- Completely Disagree; 10- Completely Agree**	
3a. When someone does me a favor, I am willing to return it.	☐
3b. If I am treated very unjustly, I will take revenge at the first occasion, even if there is a cost to do so.	☐
3c. I assume that people have only the best intentions	☐
4. How willing are you to give to good causes without expecting anything in return? (on a scale of 0 to 10) **0- Completely unwilling to do so;10- Very willing to do so**	☐

APPENDIX A.2 | *Sub-Study 2 - Food Insecurity*

***NOTE**: Delhi only; n = yet to decide.*

HOUSEHOLD FOOD INSECURITY ACCESS SCALE (HFIAS) MEASUREMENT TOOL		
1. In the past four weeks, did you worry that your household would not have enough food?	1- Yes 2- No (skip to Q2)	☐
1a. How often did this happen?	1- Rarely (once or twice in the past four weeks) 2- Sometimes (three to ten times in the past four weeks) 3- Often (more than ten times in the past four weeks)	☐
2. In the past four weeks, were you or any household member not able to eat the kinds of foods you preferred because of a lack of resources?	1- Yes 2- No (skip to Q3)	☐
2a. How often did this happen?	1- Rarely (once or twice in the past four weeks) 2- Sometimes (three to ten times in the past four weeks) 3- Often (more than ten times in the past four weeks)	☐
3. In the past four weeks, did you or any household member have to eat a limited variety of foods due to a lack of resources?	1- Yes 2- No (skip to Q4)	☐
3a. How often did this happen?	1- Rarely (once or twice in the past four weeks) 2- Sometimes (three to ten times in the past four weeks) 3- Often (more than ten times in the past four weeks)	☐
4. In the past four weeks, did you or any household member have to eat some foods that you really did not want to eat because of a lack of resources to obtain other types of food?	1- Yes 2- No (skip to Q5)	☐
4a. How often did this happen?	1- Rarely (once or twice in the past four weeks) 2- Sometimes (three to ten times in the past four weeks) 3- Often (more than ten times in the past four weeks)	☐
5. In the past four weeks, did you or any household member have to eat a smaller meal than you felt you needed because there was not enough food?	1- Yes 2- No (skip to Q6)	☐
5a. How often did this happen?	1- Rarely (once or twice in the past four weeks) 2- Sometimes (three to ten times in the past four weeks) 3- Often (more than ten times in the past four weeks)	☐
6. In the past four weeks, did you or any other household member have to eat fewer meals in a day because there was not enough food?	1- Yes 2- No (skip to Q7)	☐
6a. How often did this happen?	1- Rarely (once or twice in the past four weeks) 2- Sometimes (three to ten times in the past four weeks) 3- Often (more than ten times in the past four weeks)	☐
7. In the past four weeks, was there ever no food to eat of any kind in	1- Yes 2- No (skip to Q8)	☐

your household because of lack of resources to get food?		
7a. How often did this happen?	1- Rarely (once or twice in the past four weeks) 2- Sometimes (three to ten times in the past four weeks) 3- Often (more than ten times in the past four weeks)	☐
8. In the past four weeks, did you or any household member go to sleep at night hungry because there was not enough food?	1- Yes 2- No (skip to Q9)	☐
8a. How often did this happen?	1- Rarely (once or twice in the past four weeks) 2- Sometimes (three to ten times in the past four weeks) 3- Often (more than ten times in the past four weeks)	☐
9. In the past four weeks, did you or any household member go a whole day and night without eating anything because there was not enough food?	1- Yes 2- No (Thank the participant and end the questionnaire)	☐
9a. How often did this happen?	1- Rarely (once or twice in the past four weeks) 2- Sometimes (three to ten times in the past four weeks) 3- Often (more than ten times in the past four weeks)	☐

APPENDIX A.3 | *Sub-Study 3 – Early Life Exposures*

***NOTE**: Delhi and Chennai; 500 participants/ site **age ≥ 40**.*

SECTION A: BIRTH CIRCUMSTANCES

"(NAME), thank you for your continued participation in the CARRS study. We will start out with questions related to your place of residence at birth and early childhood. This will help us get an understanding of your early life. Please know that any information you share with us will remain confidential. To confirm we have the correct details, your date of birth is __/__/____ (dd/mm/yyyy)."

***NOTE**: Once date of birth has been confirmed against baseline survey information, please proceed with QA1.*

No.	Question
A1.	Where were you born? *"This could be the name of state, district, block, and village or city, where you were born."* ***NOTE**: Please read out each of the response categories and enter response in the box provided or circle.*

Response

i. State	ii. District	iii. Block/ thana/tehsil	iv. Village/ City	v. Pin code

Don't know 999

Don't remember..... 666

Refused..... 888

No.	Question	Response	Skip
A2.	What was your exact weight at birth? ***NOTE**: Please enter response.*	_____ (kilogram) Don't know ..... 999 Don't remember ..... 666 Refused 888	 → A2a. → A2a. → A2a.
A2a.	How do you think your birth weight compared to other babies born around the time? ***NOTE**: Please select response.*	i. Smaller than average .....1 ii. Larger than average.....2 iii. Average .....0 iv. Don't know..... 999 v. Don't remember ..... 666 vi. Refused 888	
A3.	Do you know if there were there any complications during your birth that required medical attention or a longer duration of stay in the hospital? ***NOTE**: Read complications as listed in Q A3a.*	i. Yes ..... 1 ii. No ..... 2 iii. Don't know..... 999 iv. Don't remember ..... 666 v. Refused 888	 → Sec. B → Sec. B → Sec. B → Sec. B
A3a.	If yes, which of these complications do you think you experienced? ***NOTE**: Read out responses. More than 1 answer is possible. Select all that apply.*	i. Prematurity Yes.....1 No.....2 Don't know.. 999 Don't remember..666 ii. Infections Yes.....1 No.....2	

		Don't know.. 999 Don't remember..666 iii. Difficulty breathing Yes…….1 No……..2 Don't know.. 999 Don't remember..666 iv. Intensive care Yes…….1 No…….2 Don't know.. 999 Don't remember..666 v. Low birth weight Yes…….1 No…….2 Don't know.. 999 Don't remember..666 vi. Other _____ Yes…….1 No……..2 Don't know.. 999 Don't remember..666 vii. Refused …… 888	→ Sec. B

SECTION B: CHILDHOOD HOUSEHOLD

"(NAME), thank you for sharing details of your birth with us. Now, we would like to learn about members in your childhood home. Childhood is the time from birth until the time you turned 18 years or moved out of your home for further studies or work or marriage. We will start with persons you lived with at particular times in your childhood. "

No.	Question		
B1.	At age 10, how many members resided with you in your childhood household? ***NOTE***: Please enter response.	i. _____ (number) ii. Don't know…… 999 iii. Don't remember …..... 666 iv. Refused …… 888 v. Other _____777 vi. Not applicable ……555	

B1a.

a. Please tell us about key members of your childhood household at age 10 years and, how they were related to you.

b. For each member, please tell us about where they currently reside.

"*We will start with your parents and then move on to other family members in your childhood home."*

NOTE*: We are interested in obtaining information about the vital status of the immediate family of the participant during their childhood. We will focus on the primary caregivers (the person/s primarily responsible for the upbringing of the participant as a child), the head of the household (the person with decision making power in the home) and other immediate family members of the participant. Start with respondent's parents, then move onto siblings and then grandparents. Indicate if sibling was older/younger and include relationship of each member. E.g. Older sister, Father's sister, etc.*

For each member, please ask after their current vital status by inquiring where they reside. If they state the name of a place, then enter alive; anything else, enter deceased.

Enter response in table below.

Response

#	i. Relationship to respondent	ii. Current status
		Alive…1 Deceased….0 Don't know…… 999 Don't remember …..... 666 Refused ……..... 888 Other _____777

		Not applicable ……555
1.		
2.		
3.		
4.		
5.		
6.		
7.		

No.	Question	Response	Skip
B2.	Did members of your household change meaningfully over the course of your childhood ? *"Examples of meaningful change could be a change in family structure from joint to nuclear or the loss or gain of multiple family members."* ***NOTE**: Please select response*.	i. Yes ……1 ii. No ……2 iii. Don't know…… 999 iv. Don't remember …. 666 v. Refused ……888	

"The next few questions pertain to your place of residence during childhood ."

SECTION C: RESIDENTIAL HISTORY

"(NAME), thank you for sharing with us details of your family. I would like to again assure you that all the information you share with us today will be kept confidential. Over the next few questions, we will discuss the location of your homes growing up."

No.	Question
C1.	To the best you can recollect, please tell us the location of the homes you lived in from birth to 18 years of age. a. *"The location could be the state, district, block, village/city or pin code you resided at."* b. *" When possible, tell us the year you lived at that home."* ***NOTE**: Please enter responses in table below.*

Responses						
#	**i. Start year (yyyy)**	**ii. State**	**iii. District**	**iv. Block/thana/ tehsil**	**v. Village/City**	**vi. Pin code**
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
Don't know …… 999						
Don't remember…… 666						

Refused…… 888			
"Thank you for sharing with us details of your residential history. The next few questions pertain to your health during childhood (i.e., until the time you turned 18 years or moved out of your childhood home for further studies/ work or marriage)."			
SECTION D: NUTRITION IN INFANCY			
"First, let us start with your diet and nutrition you received during infancy."			
No.	**Question**	**Response**	**Skip**
D1.	Were you breast-fed starting immediately from birth? ***NOTE**: Please select response.*	i. Yes …… 1 ii. No …… 2 iii. Don't know…… 999 iv. Don't remember …….. 666 v. Refused …….. 888	→ D1a. → D2. → D2. → D2. → D2.
D1a.	In the first three days after your birth, were you given anything to drink other than breastmilk?	i. Yes …… 1 ii. No …… 2 iii. Don't know…… 999 iv. Don't remember …….. 666 v. Refused …….. 888	→ D1b. → D3. → D3. → D3. → D3.
D1b.	What else were you given to drink in the first three days of your life?	i. Milk (other than mothers breast milk) ii. Water iii. Sugar or Glucose water iv. Gripe water v. Sugar-salt solution vi. Fruit juice vii. Infant formula viii. Honey ix. Other _____ x. Don't know…… 999 xi. Don't remember …….. 666 xii. Refused …….. 888	→ D3. → D3. → D3. → D3. → D3. → D3. → D3. → D3. → D3. → D3. → D3. → D3.
D2.	What was the reason you were not breastfed? ***NOTE**: Read out responses. More than 1 answer is possible. Select all that apply.*	i. Lack of knowledge ii. Against social norms iii. Lack of family and social support iv. Problems with lactation v. Lack of support at workplace vi. Assumption that formula is an equivalent vii. Maternal infections viii. Maternal illness (non-infectious) ix. Maternal surgery x. Maternal medication use xi. Healthcare provider recommendation xii. Infant illness xiii. Infant pain or discomfort xiv. Infant stress or distraction xv. Other reason _____ xvi. Don't know…… 999	→ D4.

		xvii. Don't remember …….. 666 xviii. Refused …….. 888	→ D4. → D4.
D3.	What was the duration of breastfeeding? ***NOTE**: Please select or enter response.*	_____ (days/ months) Don't know…….. 999 Don't remember …….. 666 Refused …….. 888	 → D3a. → D3a. → D3a.
D3a.	Were you exclusively breast-fed? ***NOTE**: Please define exclusive breast feeding as stated below for the respondent.* *"Exclusive breastfeeding means that you received only breast milk for the first 6 months of life. You did not receive any other liquids or solids- not even water. The exception is oral rehydration solution, or drops/syrups of vitamins, minerals or medicines as needed."* ***NOTE**: Please select response.*	i. Yes …….. 1 ii. No …….. 2 iii. Don't know…….. 999 iv. Don't remember …….. 666 v. Refused …….. 888	 → D4. → D4. → D4. → D4.
D4.	What kind of alternate feed was given? ***NOTE**: Please select and/or enter the response, multiple options are possible.* *"Mixed or top feed means, in addition to breast-milk, you received infant formula."*	i. Mixed feed ii. Top feed iii. Other _____ iv. Don't know…….. 999 v. Don't remember …….. 666 vi. Refused …….. 888	 → Sec. E → Sec. E → Sec. E

"Thank you for sharing details of your diet in infancy, next we will discuss your health in childhood."

SECTION E: HEALTH IN CHILDHOOD

"Now, let us move onto vaccinations you may have received in childhood."

***NOTE:** Childhood is the time from birth until the time the participant turned 18 years or moved out of their home for further studies or work or marriage.*

No.	Question	Response	Skip
E1.	As a child, did you receive any vaccinations? *"Vaccinations may have been administered as an injection,(for example the BCG vaccine is given in the upper arm and usually leaves a characteristic mark) or orally, in the form of drops (for example, the oral Polio vaccine)"* ***NOTE**: Please select response.*	i. Yes …….. 1 ii. No …….. 2 iii. Don't know…….. 999 iv. Don't remember …….. 666 v. Refused …….. 888	→ E1a. → E2. → E2. → E2. → E2.
E1a.	Which vaccinations did you receive? ***NOTE**: More than 1 response is possible; circle all that apply.*	i. BCG (for tuberculosis) Yes…….1 No……..2 Don't know….. 999 Don't remember…. 666 ii. Polio Yes…….1 No……..2	

	*If respondent chooses **"Other"** - briefly enter response.*	Don't know..... 999 Don't remember.... 666 iii. Measles Yes.......1 No........2 Don't know..... 999 Don't remember.... 666 iv. Measles Mumps Rubella Yes.......1 No.......2 Don't know..... 999 Don't remember.... 666 v. Diphtheria Pertussis Tetanus Yes.......1 No........2 Don't know..... 999 Don't remember.... 666 x. Other ________________ Yes.......1 No........2 Don't know..... 999 Don't remember.... 666 xi. Refused 888	

"*Next we will talk about any illnesses you had as a child.*"

***NOTE**: For any question that refers to childhood, please indicate to the respondent that this refers to the time from birth up until they turned 18 years or moved out of their home for further studies/work/marriage.*

E2.	Did you experience any illness as a child? ***NOTE**: Please select response.*	i. Yes .... 1 ii. No .... 2 iii. Don't know.......................... 999 iv. Don't remember .... 666 v. Refused 888	→ E2a. → Sec. F → Sec. F → Sec. F → Sec. F
E2a.	Do you know what illness you experienced? ***NOTE**: Please read out options to respondent.* *More than 1 is possible. Please select all that apply.* *If respondent chooses **"Other"** - briefly enter response.*	i. Measles Yes.......1 No........2 ii. Chickenpox Yes.......1 No........2 iii. Mumps Yes.......1 No........2 iv. Whooping cough Yes.......1 No.......2 v. Diarrhea Yes.......1 No.......2 vi. Worm infection Yes.......1 No.......2 vii. Respiratory infection Yes.......1 No........2 viii. Tuberculosis Yes.......1 No........2 ix. Typhoid Yes.......1 No........2 x. Bronchitis/ Asthma Yes.......1 No........2 xi. Eye infections (Red eye) Yes.......1 No.......2 xii. Other illness ________________ Yes.......1 No........2 xiii. Don't know.......................... 999 xiv. Don't remember 666	 → Sec. F → Sec. F

		xv. Refused 888	→ Sec. F
E2b.	Did you ever seek care for your illness? *"This could be from an Allopathic/ medical, Ayurvedic, Homeopathic, Naturopathic, Unani, Siddha or other practitioner."* ***NOTE**: Please select response.*	i. Yes ..... 1 ii. No ..... 2 iii. Don't know..... 999 iv. Don't remember ..... 666 v. Refused 888	→ E3. → E2c → E3. → E3. → E3.
E2c.	What were the reasons for you to not seek medical care? ***NOTE**: Please read out options to respondent.* *More than 1 is possible. Please select all that apply.* *If respondent chooses **"Other" -** briefly enter response.*	i. Expensive Yes.....1 No.....2 ii. Too far away Yes.....1 No.....2 iii. No healthcare worker Yes.....1 No.....2 iv. Other_____ v. Don't know..... 999 vi. Don't remember ..... 666 vii. Refused 888	
E3.	Did you have repeated bouts of any illness? ***NOTE**: Please select response.*	i. Yes ..... 1 ii. No ..... 2 iii. Don't know..... 999 iv. Don't remember ..... 666 v. Refused 888	→ E3a. → Sec F → Sec F → Sec F → Sec F
E3a.	Can you specify which illness? ***NOTE**: Please select response.*	i. _____ ii. _____ iii. _____ iv. _____ v. _____ vi. Don't know..... 999 vii. Don't remember ..... 666 viii. Refused 888	→ E3b. → E3b → Sec F
E3b.	Were you ever hospitalized for this illness? ***NOTE**: Please select response.*	i. Yes ..... 1 ii. No ..... 0 iii. Don't know..... 999 iv. Don't remember ..... 666 v. Refused 888	→ E3c → Sec F → Sec F → Sec F → Sec F
E3c.	Can you share details of your hospital stay? *"To the best of your recollection, please tell us (i.) the reason for hospitalization, (ii.) age at hospitalization and the (iii.) duration of your stay in the hospital."* ***NOTE**: Please enter response in table below.*		

Response			
#	**i. Reason for hospitalization**	**ii. Age at hospitalization (MMYY)**	**iii. Duration of stay (DDMM)**
1.			

2.			
3.			
4.			
5.			
6.			
Don't know 999			
Don't remember.. 666			
Refused... 888			
"Thank you for sharing with us details of your medical history. The next few questions pertain to your education and work."			

SECTION F: EDUCATION AND OCCUPATION

"(NAME), thank you for sharing with us details of your medical history. Over the next few questions, we will explore details of yours and, members of your family' education. To start off, lets discuss your education. In an earlier visit, you stated that you had completed ____________."

NOTE: *Please cross-check the participant education level from the baseline survey and incorporate it here as you ask the question. For e.g. .. "In an earlier visit, you stated that you had no formal education or completed graduate education."*

If participant has discontinued education before completing undergraduate studies then proceed with QF1; anything else, proceed with QF2.

No.	Question	Response	Skip
F1.	What were the reasons for not being able to go to school/ continue schooling? ***NOTE***: *If respondent has said they did not attend school, please ask what the reasons were for the same.* *If respondent has said they did primary and then stopped (up to undergraduate), then please ask why they did not continue.* *Please select response, multiple response options are possible. If respondent chooses **"Other"**, briefly enter response.*	i. Not interested Yes ....1 No............2 ii. Cost Yes ....1 No............2 iii. Distance Yes ....1 No............2 iv. Sanitation Yes ....1 No............2 v. Was working Yes ....1 No............2 vi. Gender Yes ....1 No............2 vii. Family decision Yes ....1 No............2 viii. Absence of school/ teachers Yes ....1 No............2 ix. Other ______________________ x. Don't know.............................. 999 xi. Don't remember .... 666 xii. Refused 888	 → F2 → F2 → F2

No.	Question
	If no formal schooling, skip to F3
F2.	Can you tell us more about your schooling experience? "*Specifically, when you attended* (READ OUT EACH LEVEL OF SCHOOLING SEPARATELY, EG. PRIMARY), i. *Did you go to a private school, a government aided school or a government school?*

ii. *How many students were in your class? (Numeric response)*

iii. *What was the language of instruction?*

***NOTE**: Please only collect information on the participants schooling experience up to class 12. Please enter their response in the table. If respondent changed schools, please enter in the blank spaces provided. i.e. Line 5 onward). If the participant has completed a technical or vocational training after class 10 and in place of class 11-12, please enter the details of their experience in the 'Other' header in the column titled, 'Level of schooling.'*

Response

#	Level of schooling	i. Type of school a. Private school 1 b. Government aided school2 c. Government school3 d. Don't know ……..999 e. Don't remember …666 f. Refused ……888	ii. Class size	iii. Medium a. Hindi 1 b. Tamil 2 c. English 3 c. Other _____ d. Don't know ……..999 e. Don't remember …666 f. Refused ……888
1	Lower Primary (Class 1-5)			
2	Upper Primary (Class 6-8)			
3	High School/Secondary (Class 9,10)			
4	Higher Secondary (Class 11, 12)			
5	Other			
6				
7				
8				

"Thank you for sharing details of your education with us. We would now like to discuss similar details related to the education and occupation of members of your childhood household."

No.		Question
F3.		Can you tell us about the schooling and occupation of members of your childhood household? *"Specifically, we would like to know about members of your immediate family." (LISTED BELOW IN TABLE). "For each member, please tell us the following,* *i. Level of completed schooling* *ii. Occupation while you lived in their home"* ***NOTE**: Childhood is the time from birth until the time the participant turned 18 years or moved out of their home for further studies or work or for marriage. Please ask about respondents' parents and grandparents. If the primary caregiver and head of household are not among these members, ask about them separately. Please enter response in table. Please read options from Q. F2 for level of education.*

Response

#	Member	Relationship to participant	i. Highest education level a. Lower Primary (Class 1-5)1 b. Upper Primary (Class 6-8)2 c. High School/Secondary (Class 9,10)3 d. Higher Secondary (Class 11, 12)4 e. No formal education5	ii. Occupation a. Government employee-1 b. non-government employee-2 c. Self-employed-3 d. non-paid4 e. Student5 f. Homemaker6 g. Retired7

			f. Other _____ f. Don't know…….. 999 g. Don't remember …….. 666 h. Refused …….. 888	h. Unemployed (able to work)8 i. Unemployed (unable to work)9 j. Don't know…….. 999 k. Don't remember……. 666 l. Refused …….. 888
1.	Head of household			
2.	Primary caregiver			

SECTION G: SOCIAL AND EMOTIONAL SUPPORT

"Over the next few questions, we will be asking you about your social and emotional well-being. Please know that all the information you share with us will be kept confidential."

No.	Question	Response	Skip
G1.	On days when you are not feeling satisfied with your life or are feeling anxious or unhappy, who do you reach out to for support? ***NOTE**: Please select response, multiple response options are possible.*	i. Parent Yes …….1 No ……..2 ii. Sibling Yes …….1 No ……..2 iii. Friend Yes …….1 No ……..2 iv. Partner Yes …….1 No ……..2 v. Child Yes …….1 No ……..2 vi. Professional Yes …….1 No ……..2 vii. Self Yes …….1 No ……..2 viii. Other ……. ix. Don't know…….. 999 x. Don't remember …….. 666 xi. Refused …….. 888	→ G2 → G2 → G2
G2.	How long does it take you to reach your parental home? ***NOTE**: Please enter or select response.*	i. __ __ (hours) ii. Not applicable ……555 iii. Don't know…….. 999 iv. Don't remember …….. 666 v. Refused …….. 888	→ G3 → G3 → G3
G3.	How often do you visit your parental home in a year? ***NOTE**: Please enter or select response.*	i. Less than once a year ii. More than once a year: __ __/year ii. Not applicable ……555 iii Don't know…….. 999	

		iv. Don't remember …….…….. 666 v. Refused …….…….. 888	

If 555 for male, finish the questionnaire and thank the participant
If female, go to section H

SECTION H: MARITAL AND REPRODUCTIVE HISTORY

"Over the next few questions, we will be asking you about your marriage and marital home. Please know that all the information you share with us will be kept confidential."

***NOTE**: For participants of the original survey who identify as women and who have stated that they are currently or were previously married, please proceed to Q.H1. For all others, this completes the survey. Please proceed to the measurements section."*

No.	Question	Response	Skip
H1.	What was your age at first marriage? ***NOTE**: Please enter response.*	__ __ (years) Don't know…….…….. 999 Don't remember …….…….. 666 Refused …….…….. 888	

***NOTE**: The next question is only to be asked to respondents who have identified as women and have stated that they have had at least one pregnancy. For all else, skip to the measurements section and read the script there.*

*PLEASE SAY THIS TO THE WOMEN,
"The next few questions pertain to your reproductive history. Please know we can stop anytime you feel uncomfortable."

No.	Question
H2.	Can you share with us details of each of your pregnancies? *"Starting with the first pregnancy, please tell us:* *i. Your age at pregnancy* *ii. How many months were you pregnant?* *iii. What was the outcome of the pregnancy? **NOTE**: Read out choices.* *iv. What complications did you experience? **NOTE**: Read out choices.* ***NOTE**: Please enter response in table; please read options as indicated.*

Response				
#	i. Age at pregnancy (in years)	ii. Duration of pregnancy (in months)	iii. Outcome PLEASE CHOOSE FROM: i. Live birth Yes…….1 No……..2 ii. Premature (live birth) Yes…….1 No……..2 iii. Stillbirth Yes…….1 No……..2 iv. Miscarriage	iv. Complications PLEASE CHOOSE FROM: i. None Yes…….1 No……..2 ii. Medical (Diabetes, Hypertension, Thyroid disorders etc.) Yes…….1 No…….2 iii. Surgical (Appendicitis, Cholecystitis, Intestinal obstruction, Breast surgery, Ectopic pregnancy etc.)

			Yes…….1 No……..2 v. Abortion Yes…….1 No……..2 vi. Other ……. vii. Don't know…….. 999 viii. Don't remember ……..…….. 666 ix. Refused …..…….. 888	Yes…….1 No……..2 iv. Other _____ v. Don't know…….. 999 vi. Don't remember ……..…….. 666 vii. Refused …..…….. 888
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

SECTION I: ANTHROPOMETRY

"(NAME), thank you for sharing with us details of your support system. We would now like to measure your height in both, the sitting and standing position. This will allow us to determine your leg length and trunk length which will provide important information on growth in your childhood."

No.	Question	Response	
I1.	Standing height ***NOTE**: Please enter response.*	__ __ __. __ (centimetre)	Instrument ID __ __
I2.	Sitting height ***NOTE**: Please enter response.*	__ __ __. __ (centimetre)	Instrument ID __ __
I3.	Problems experienced during anthropometric measurements ***NOTE**: Please select response.*	i. None Yes …….1 No …….2 ii. Multiple attempts required Yes …….1 No …….2 iii. Patient refused measurements Yes …….1 No …….2 iv. Others (Specify): _____	

SECTION J: BLOOD SAMPLE COLLECTION

"We are now at the last section of our study. We will end with blood sample collection for the purpose of measuring a substance called homocysteine. Homocysteine levels in blood give us an understanding of our risk for heart disease. Please know that we will inform you if your levels are higher than normal and that all your information will be kept confidential."

No.	Question	Response
J1.	Date of collection	__ __/__ __/__ __ __ __ (dd/mm/yyyy)
J2.	Date of last meal	__ __/__ __/__ __ __ __ (dd/mm/yyyy)
J3.	Time of last meal	__ __/__ __ (Military time)
J4.	Time of collection	__ __/__ __ (Military time)
J5.	Medical complications experienced by patient at the time of blood collection ***NOTE**: Please select response*.	i. None Yes …….1 No …….2 ii. Fainting. Yes …….1 No …….2 iii. Light-headedness Yes …….1 No …….2 iv. Hematoma Yes …….1 No …….2 v. Bruising Yes …….1 No …….2 vi. Other (Specify): _____ Comments: _____ _____ _____ _____
J6.	Tubes collected ***NOTE**: Please select response*.	Lavender top Yes …….1 No …….2
J7.	Problems experienced during blood collection ***NOTE**: Please select response*.	v. Not drawn vi. None vii. Short draw viii. Damaged tube ix. Multiple attempts required x. Others (Specify): _____
J8.	Patient refused blood sample collection	Yes …….1 No …….2

APPENDIX A.4 | *Sub-Study 4 – Multi-Morbidity*

***NOTE**: Delhi and Chennai; 1150 participants/site **age ≥ 40**.*

MULTI-MORBIDITY

*Diseases from Medical History Section

If answer to the **underlined diseases below** was "Yes" in **Medical History Section**, then ask following questions.

How much does **diabetes** limit your daily activities?	Not at all = 1 A little = 2 Somewhat = 3 A lot = 4 Quite a lot = 5
How much does **hypertension** limit your daily activities?	Not at all = 1 A little = 2 Somewhat = 3 A lot = 4 Quite a lot = 5
How much does **heart disease** limit your daily activities?	Not at all = 1 A little = 2 Somewhat = 3 A lot = 4 Quite a lot = 5
How much does **stroke** limit your daily activities?	Not at all = 1 A little = 2 Somewhat = 3 A lot = 4 Quite a lot = 5
How much does **cancer** limit your daily activities?	Not at all = 1 A little = 2 Somewhat = 3 A lot = 4 Quite a lot = 5
How much does **kidney disease** limit your daily activities?	Not at all = 1 A little = 2 Somewhat = 3 A lot = 4 Quite a lot = 5

*Additional Diseases

Disease	**Question**	Yes=1 No=2	**Year of diagnosis**	**How much does this problem limits your daily activities?** Not at all = 1 A little = 2 Somewhat = 3 A lot = 4 Quite a lot = 5
Arthritis	Have you been diagnosed with arthritis by a doctor?	☐	☐☐ ☐☐ MM YY	☐
	In the last 12 months, have you experienced pain, aching, stiffness or swelling in or around the joints (like arms, hands, legs or feet), which were not related to injury and			

	lasted for more than a month?			
Chronic Obstructive Pulmonary disease (COPD)	Have you been diagnosed with **COPD (asthma, bronchitis, emphysema)** by a doctor?	☐	☐☐ ☐☐ MM YY	☐
Acid peptic disease (gastritis)	Have you been diagnosed with **gastritis** by a doctor?	☐	☐☐ ☐☐ MM YY	☐
Chronic back ache	Have you been diagnosed with **chronic back pain** by a doctor?	☐	☐☐ ☐☐ MM YY	☐
	In last 12 months, have you had **continuous back pain** for more than 3 weeks?	☐	☐☐ ☐☐ MM YY	☐
Vision problem	Do you have **difficulty in vision** even after wearing glasses?	☐	☐☐ ☐☐ MM YY	☐
Deafness	Do you have **difficulty in hearing**?	☐	☐☐ ☐☐ MM YY	☐
Dementia *(**NOTE**: Ask this question to a family member)*	Have he/she ever been diagnosed of having **dementia** by a doctor?	☐	☐☐ ☐☐ MM YY	☐
	Do he/she have memory problems which hinders activities of daily living?	☐	☐☐ ☐☐ MM YY	☐
Alcohol disorder	Have you visited any doctor because of **alcohol disorder/s**?	☐	☐☐ ☐☐ MM YY	☐
	Are you habituated to alcohol?	☐	☐☐ ☐☐ MM YY	☐
Epilepsy	Have you ever suffered with a sudden onset of seizure/s while at work or rest?	☐	☐☐ ☐☐ MM YY	☐
	Have you ever been diagnosed with **epilepsy** by a doctor?	☐	☐☐ ☐☐ MM YY	☐
Thyroid disease	Have you ever been diagnosed with **thyroid disease** by a doctor?	☐	☐☐ ☐☐ MM YY	☐
Tuberculosis	Do you have **tuberculosis**?	☐	☐☐ ☐☐ MM YY	☐
	Are you taking any treatment for TB?	☐	☐☐ ☐☐ MM YY	☐
Other(s)	Do you have any other disease for which you are	☐		

	taking treatment for more than one month?			
	If "Yes" – Please specify.	☐	☐☐ ☐☐ MM YY	☐
Dengue (self-report)	**Have you been diagnosed with Dengue (In the past 1 year)?**	☐	☐☐ ☐☐ MM YY	☐
Malaria (self-report)	**Have you been diagnosed with Malaria (In the past 1 year)?**	☐	☐☐ ☐☐ MM YY	☐

WHO DISABILITY ASSESSMENT SCHEDULE 2.0 (WHODAS 2.0) Think back over the past 30 days and answer these questions, thinking about how much difficulty you had doing the following activities.

0 = No Difficulty | 1 = Mild Difficulty | 2 = Moderate Difficulty | 3 = Severe Difficulty | 4 = Extreme Difficulty or Cannot Do

S1	Standing for long periods such as 30 minutes	☐
S2	Taking care of your household responsibilities	☐
S3	Learning a new task, for example, learning how to get to a new place	☐
S4	How much of a problem did you have in joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?	☐
S5	How much have you been emotionally affected by your health problems?	☐
S6	Concentrating on doing something for 10 minutes?	☐
S7	Walking a long distance such as kilometer (or equivalent)	☐
S8	Washing your whole body	☐
S9	Getting dressed	☐
S10	Dealing with people you do not know	☐
S11	Maintaining a friendship	☐
S12	Your day-to-day work	☐
H1	Overall, in the past 30 days, how many days were these difficulties present?	☐
H2	In the past 30 days, for how many days were you totally unable to carry out your usual activities or work because of any health condition?	☐
H3	In the past 30 days, not counting the days that you were totally unable, for how many days did you cut back or reduce your usual activities or work because of any health condition?	☐

FRIED FRAILTY PHENOTYPE SCALE (≥50 years)		
Weight loss: Self-reported unintentional weight loss ≥5Kg in previous year	Yes$_1$ No$_2$	☐
Do you feel full of energy?	Yes$_1$ No$_2$	☐
During the last 4 weeks how often, you rested in bed during day?	Every day$_1$ Every Week$_2$ Once$_3$ Not at all$_4$	☐
How often you do mildly energetic physical activity? ***NOTE**: "mild physical activity" is activities which doesn't increase breathing or heart rate.*	>3 times per week$_1$ 1-2 times per week$_2$ 1-3 time per month$_3$ Hardly ever/never$_4$	☐
How often you do moderately energetic physical activity? ***NOTE**: "moderate-intensity activities" are activities that require moderate physical effort and cause small increases in breathing or heart rate.*	>3 times per week$_1$ 1-2 times per week$_2$ 1-3 time per month$_3$ Hardly ever/never$_4$	☐
How often you do very energetic physical activity? ***NOTE**: "vigorous-intensity activities" are activities that require hard physical effort and cause large increases in breathing or heart rate.*	>3 times per week$_1$ 1-2 times per week$_2$ 1-3 time per month$_3$ Hardly ever/never$_4$	☐
Do you have any problems from recent surgery, injury, or other health conditions that might prevent you from walking?	Yes 1 No 2	☐ If "1", skip to the next part "MINICOG"
Walking time in seconds (usual pace) over 15 feet ***NOTE**: Ask the participant to walk over 15 feet and note the time.*	☐☐ . ☐☐ Min Sec	
Was the participant able to complete the walk?	Yes 1 No 2	☐
Did the participant use any type of aid for walking?	Yes 1 No 2	☐ If No go to the next part "MINICOG"
Record type of aid used	Walking stick or cane 1 Elbow crutches 2 Walking frame 3 Other, pls specify 4	☐ Any other, pls specify _____

MINI COG (from PURE) (≥50 years) COGNITIVE FUNCTION (≥50 years)		
Have you ever attended a doctor for problems with your memory?	Yes1 No2	☐
If yes, have you have been diagnosed with dementia, Alzheimer's, or vascular dementia?	Yes1 No2	☐
If yes, have you ever been prescribed medications for your memory?	Yes1 No2	☐
If yes to meds → Medication Data Form		

STEP 1: Three Word Registration

Look directly at the person and say: "Please listen carefully. I am going to say three words that I want you to repeat back to me now and try to remember. The words are [read out words from Version 1 below]. Please say them for me now." If the person is unable to repeat the words after three attempts, move on to Step 2 (clock drawing).

Hindi	Tamil	English
के ला	q u| p ú i p ù	Banana
सुबह	∑ Ĩ k ÈWf k ù	Sunrise
कु स	g u† _ un v	Chair

STEP 2: Clock Drawing *(3 minute time-limit)*

Say: "Next, I want you to draw a clock for me. First, put in all of the numbers where they go." When that is completed, say: "Now, set the hands to 10 past 11."

Repeat instructions as needed as this is not a memory test. Move to Step 3 if the clock is not complete within three minutes.

Picture Taking on Tablet: Once participant has completed this step, take a picture on the tablet.

It is ***very*** important that you review the picture you have taken it and ensure the following:

1. *Subject ID*, *Subject Initials,* and *Follow-up Visit Number* are all included in the picture.
2. Picture is taken in ***Portrait mode*** and is ***clear*** (i.e. ensure the entire clock is visible, and the image is not blurry)

STEP 3: Word Recall

Ask the person to recall the three words you stated in Step 1. Say: "What were the three words I asked you to remember?" Record the participant's answer.

SCORING	
Word Recall: 0-3 points	1 point for each word spontaneously recalled without cueing
Clock Draw: 0 or 2 points	Normal clock = 2 points. A normal clock has all numbers placed in the correct sequence and approximately correct position (e.g. 12, 3, 6 and 9 are in anchor positions) with no missing or duplicate numbers. Hands are pointing to the 11 and 2 (11:10). Hand length is not scored. Inability or refusal to draw a clock (abnormal) = 0 points
Total Score: 0-5 points	Total score = Word Recall score + Clock Draw score.

STEP 1: Word Registration

Important Reminder: Please complete Word Registration (Step 1) exercise found on the facing page before proceeding to the Clock Drawing (Step 2) exercise.

STEP 2: Clock Drawing *(3 minute time-limit)*

Was the participant unable or refused to draw the clock?

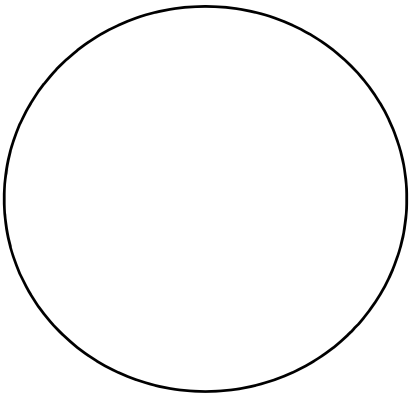
Yes ☐ No ☐

Are all numbers placed in the correct sequence and approximately the correct position (e.g. 12, 3, 6 and 9 are in no anchor positions) with no missing or duplicate numbers?

Yes ☐ No ☐

Are all the hands pointing to the 11 and 2 (11:10). Hand length is irrelevant/not scored.

Yes ☐ No ☐



Score: ___/2

STEP 3: Word Recall

Participant's Answers: _____ _____ _____

Score: ___/3

Total Score: ___/5

APPENDIX B.1 | *Angina Report (Pure Module)*

NOTE: For those who answered "yes" to having been diagnosed with **Angina** in the Cardiovascular History section of this questionnaire.

1. Angina Diagnosis	New Diagnosis 1 Worsening angina 2 Unstable angina 3	☐ **If "1" go to Q3**
2. Do you know the exact date of original angina diagnosis (1= Yes; 2= No; 999= Don't know)	☐ if 2 or 999, go to 2b	
2a. If **yes,** date of original angina diagnosis	☐☐☐☐ ☐☐ Year Month	
2b**. If worsening or unstable only**: was there increased in frequency?	Yes 1 No 2 Don't know 999	☐
2c**. If worsening or unstable only:** was there increased in severity?	Yes 1 No 2 Don't know 999	☐
2d**. If worsening or unstable only**: was there increased in duration?	Yes 1 No 2 Don't know 999	☐
3. Do you know the date of diagnosis of NEW angina or date of worsening / unstable angina, after initial diagnosis? (1= Yes; 2= No, 999 =Don't know)	☐ If "2" or "999" go to Q4	
3a. If **yes**, date of diagnosis of NEW angina or date of worsening / unstable angina, after initial diagnosis	☐☐☐☐ ☐☐ Year Month	
4. Were you hospitalized? *(Note: Overnight stay)*	Yes 1 No 2	☐ If "1" – go to 4a, If "2" – go to 4e and skip to main questionnaire
4a Do you know the exact date of hospitalization?	Yes 1 No 2 Don't know 999	☐ If "999", go to Q4c
4b. If yes, please enter the date of hospitalization	☐☐☐☐ ☐☐ Year Month	
4c. Number of days in hospital	☐☐☐	
4d. Number of days off work or usual activities (including hospital stay)	☐☐☐	
4e If not hospitalized, what was the reason? Yes=1; No=2 *(Multiple choice)*	a) Event did not need hospitalization b) Visited a clinic/ medical professional c) Visited a traditional healer d) Could not get transportation on time	☐ ☐ ☐ ☐ ☐

	e) Could not afford transportation f) Could not afford hospital care g) Other, specify_____	☐ ☐
5. Were the given tests performed? (Yes =1, No=2, Don't Know=999)	a) ECG/ Stress test b) Stress Echocardiogram performed c) Blood test performed	☐ ☐ ☐
5d. If "1" for any of the above (5a- 5c), was there evidence of ischemia?	Yes 1 No 2 Don't know 999	☐
6. Did you have a coronary angiography performed?	Yes 1 No 2 Don't know 999	☐
7. Have you undergone CABG (open bypass) surgery?	Yes 1 No 2 Don't know 999	☐
8. Did you have PCI/PTCA (Stent)?	Yes 1 No 2 Don't know 999	☐
9. Do you have any supporting medical document?	Yes 1 No 2 Refused 888	☐ If "2 or 3" skip to the main questionnaire
9a. Please make digital copy of available supporting documents of the participant. Yes 1 No 2	Discharge report Consultation notes Prescription Lab Reports Other If Other, specify _____	☐ ☐ ☐ ☐ ☐

APPENDIX B.2 | *Heart Failure Report (Pure Module)*

NOTE: For those who answered **"yes"** to having been diagnosed with **Heart Failure** in the Cardiovascular History section of this questionnaire.

1. Do you know the exact date of heart failure diagnosis (1= Yes; 2= No; 999= Don't know)	☐ if 2 or 999, go to Q2	
1a. If yes, date of heart failure diagnosis	☐☐☐☐ Year ☐☐ Month	
2. Were you hospitalized? *(Note: Overnight stay)*	Yes 1 No 2	☐ If "1" – go to Q3, If "2" go to 2a
2a If not hospitalized what was the reason? *(Multiple choice)* Yes 1 No 2	a. Event did not need hospitalization b. Visited a clinic/ medical professional. c. Visited a traditional healer d. Could not get transportation on time e. Could not afford transportation f. Could not afford hospital care g. Other, specify_____	☐ ☐ ☐ ☐ ☐ ☐ ☐ check all that apply and skip to Q4
3. Hospital details		
3a Do you know the exact date of hospitalization?	Yes 1 No 2 Don't know 999	☐ If "999", skip to Q3c
3b. If yes, please enter the date of hospitalization	☐☐☐☐ Year ☐☐ Month	
3c. Number of days in hospital	☐☐☐	
3d. Number of days off work or usual activities *(including hospital stay)*	☐☐☐	
3e. Address of the hospital Name City Sate/Province		
3f. Type of hospital	Government 1 Non-Government/Private 2	☐
3g. What was the mode of transportation to the Hospital?	Public Transportation 1 Taxi 2 Private Car 3 Walk 4 Other 777	☐ If Other, specify_____
3h. Were you transferred to another hospital for further care?	Yes 1 No 2	☐

4. Did You experience any of the following symptoms?	Yes 1 No 2	☐ If "1" go to 4a, if "2" go to Q6
4a. What were the symptoms? **(1=Yes; 2= No)**	a) Shortness of breath during exertion b) Shortness of breath during exertion at rest c) Awaken during sleep by shortness of breath d) Swelling of feet e) Wheezing f) Other specify, _____	☐ ☐ ☐ ☐ ☐ ☐
5. Do you know how were the symptoms present before seeking medical attention?	Yes 1 No 2 Don't know 999	☐ If "1" goto 5a else go to Q6
5a. How long were the symptoms present before seeking medical attention?	☐☐ ☐☐ ☐☐ ☐☐ Minutes Hours Days Week	
6. Do you know how much time it takes to see a physician or nurse?	Yes 1 No 2 Don't know 999	☐ If "1" goto 6a else go to Q7
6a. How long did it take to see a physician or nurse? ***(NOTE: include both waiting time to obtain an appointment and waiting time once at health care facility, to see doctor or nurse)***	☐☐ ☐☐ ☐☐ ☐☐ Minutes Hours Days Week	
7. Did you have any of the following accompanying this event? (Check all that apply) **(Yes=1; No=2)**	a) Pneumonia /respiratory infection b) Other infections (specify site) Specify site _____ c) MI d) Anaemia e) Atrial fibrillation f) Mechanical ventilation g) Angina h) Other precipitating cause Specify _____	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
7a. If "1" for any of the above (Q7), did this precede the heart failure event?	**(Yes=1; No=2)** a) Pneumonia /respiratory infection b) Other infections (specify site) specify site, _____ c) MI d) Anaemia e) Atrial fibrillation f) Mechanical ventilation g) Angina h) Other precipitating cause Specify, _____	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

8. Did you have an assessment of LV function (heart function)?	Yes 1 No 2	☐ If "1" go to 8a, if "2" go to Q 9
8a. What method was used? Yes 1 No 2 Don't know 999	a) Nuclear studies b) Echo c) Angio d) Other If Other, specify _____	☐ ☐ ☐ ☐
9 Do you have any supporting medical document?	Yes 1 No 2 Refused 888	☐ If "2 or 3" skip to the main questionnaire
9a. If yes, please make digital copy of available supporting documents of the participant. Yes 1 No 2	a) Discharge report b) Consultation notes c) Prescription d) ECG e) Lab Reports f) Other If other, Specify_____	☐ ☐ ☐ ☐ ☐ ☐

APPENDIX B.3 | *Myocardial Infarction Report (Pure Module)*

NOTE: For those who answered **"yes"** to having been diagnosed with **Myocardial infarction** in the Cardiovascular History section of this questionnaire.

1. Do you know the exact date of Myocardial infarction (MI) diagnosis? (1= Yes; 2= No; 999= Don't know)	☐ if 2 or 999, go to Q2	
1a. If yes, date of MI diagnosis	☐☐☐☐ Year ☐☐ Month	
2 Were you hospitalized)? *(Note: Overnight stay)*	Yes 1 No 2	☐ If "1" go to Q3, If "2" go to Q2a
2a. If not hospitalized, what was the reason? Yes=1; No=2 *(Multiple choice)*	a. Event did not need hospitalization b. Visited a clinic/ medical professional. c. Visited a traditional healer d. Could not get transportation on time e. Could not afford transportation f. Could not afford hospital care g. Other, specify the reason _____	☐ ☐ ☐ ☐ ☐ ☐ ☐ Select all that apply and skip to Q4
3. Hospital details		
3a. Do you know the exact date of hospitalization?	Yes 1 No 2 Don't know 999	☐ If "999", skip to Q3c
3b. if yes, please enter the date of hospitalization	☐☐☐☐ Year ☐☐ Month	
3c. Number of days in hospital	☐☐☐	
3d. Number of days off work or usual Activities (including hospital stay)	☐☐☐	
3e. Address of the hospital Name City Sate/Province		
3f. Type of Hospital	Government 1 Non-Government/Private 2	☐
3g What was the mode of transportation to the hospital?	Public Transportation 1 Taxi 2 Private Car 3 Walk 4 Other 777	☐ If other, Specify_____
3h Were you transferred to another hospital for further care?	Yes 1 No 2	☐

4. Did you experience any of the following symptoms?	Yes 1 No 2	☐ If "1" go to 4a, If "2" go to Q6
4a. What were the symptoms? (1=Yes; 2= No, 999= Don't know))	a) Chest pain or discomfort ≥ 20 mins b) Pain radiating to arm, shoulder, or neck c) Sweating or vomiting d) Others If other, specify _____	☐ ☐ ☐ ☐
5. Do you know how long the symptoms present before seeking medical attention?	Yes 1 No 2 Don't know 999	☐ If "1" go to 5a else go to Q6
5a. How long were the symptoms present before seeking medical attention?	☐☐ ☐☐ ☐☐ ☐☐ Minutes Hours Days Week	
6. Do you know how much time it takes to see a physician or nurse?	Yes 1 No 2 Don't know 999	☐ If "1" go to 6a else go to Q7
6a. How long did it take to see a physician or nurse? (***NOTE: include both waiting time to obtain an appointment and waiting time once at health care facility, to see doctor or nurse)***	☐☐ ☐☐ ☐☐ ☐☐ Minutes Hours Days Week	
7. Were any blood test done?	Yes 1 No 2 Don't know 999	☐
8. Have you received any of the following? (Yes=1; No=2; Don't know=999)	a) Thrombolytic therapy b) PCI (Stent) c) CABG Surgery	☐ ☐ ☐
9. Do you have any supporting medical document?	Yes 1 No 2 Refused 888	☐ If "2 or 3" skip to the main questionnaire
9a. If yes, please make digital copy of available supporting documents of the participant. Yes 1 No 2	a) Discharge report b) Consultation notes c) Prescription d) ECG e) Lab reports f) Other If Other, Specify_____	☐ ☐ ☐ ☐ ☐ ☐

APPENDIX B.4 | *Stroke Report (Pure Module)*

NOTE: For those who answered "yes" to having been diagnosed with a **Stroke** in the cardiovascular history section of this questionnaire.

1. Do you know the exact date of stroke diagnosis (1= Yes; 2= No; 999= Don't know)	☐ if 2 or 999, go to Q2	
1a. If yes, date of stroke diagnosis	☐☐☐☐ Year ☐☐ Month	
2. Were you hospitalized? *(Note: Overnight stay)*	Yes 1 No 2	☐ If "1" – go to Q3, If "2" – go to 2a
2a. If not hospitalized, what was the reason? *(Multiple choice)* Yes 1 No 2	a. Event did not need hospitalization b. Visited a clinic/ medical professional. c. Visited a traditional healer d. Could not get transportation on time e. Could not afford transportation f. Could not afford hospital care g. Other, specify_____	☐ ☐ ☐ ☐ ☐ ☐ ☐ Select all that apply and skip to Q4
3.Hospital details		
3aDo you know the exact date of hospitalization?	Yes 1 No 2 Don't know 999	☐ If "999", skip to Q3c
3b. if yeas please enter the date of hospitalization?	☐☐☐☐ Year ☐☐ Month	
3c. Number of days in hospital	☐☐☐	
3d. Number of days off work or usual Activities *(including hospital stay)*	☐☐☐	
3e. Address of the Hospital Name City Sate/Province		
3f. Type of Hospital	Government 1 Non-Government/Private 2	☐
3g. What was the mode of transportation to the Hospital?	Public Transportation 1 Taxi 2 Private Car 3 Walk 4 Other 5	☐ If other, specify_____
3h. Were you transferred to another hospital for further care?	Yes 1 No 2	☐

4. Did you receive any therapies as in-patient or out-patient?	Yes 1 No 2	☐
4a If yes which of the following therapies did you receive as in-patient or out- patient? Yes=1, No=2 *(Check all that apply)*	a) Physiotherapy b) Occupational therapy c) Speech and language therapy d) Other if other, specify_____	☐ ☐ ☐ ☐ ☐
5. Did you experience any symptoms during presentation?	Yes 1 No 2	☐ If "1" go to 5a, if "2" go to Q6
5a. What were the symptoms? **(1=Yes; 2= No, 999= Don't know**)	i. Did you become unconscious or drowsy? ii. Was there loss of vision? iii. Was there weakness in face or limbs? iv. Was there weakness in one limb/ half the body? v. Was there difficulty in speaking? vi. Was there a disturbance of balance or walking? vii. Was there a trauma to the head or neck in the last week?	☐ ☐ ☐ ☐ ☐ ☐ ☐
5b. Was the duration of any symptoms > 24 hours?	Yes 1 No 2 Don't know 999	☐ If "1" go to 5c, else go to Q6
5c. Do you know how long were the symptoms present before seeking medical attention?	Yes 1 No 2 Don't know 999	☐ If "1" go to 5d else go to Q6
5d. How long were the symptoms present before seeking medical attention?	☐☐ ☐☐ ☐☐ ☐☐ Minutes Hours Days Week	
6. Do you know how much time it takes to see a physician or nurse?	Yes 1 No 2 Don't know 999	☐ If "1" go to 6a else go to Q7
6a. How long did it take to see a physician or nurse? *(NOTE: include both waiting time to obtain an appointment and waiting time once at health care facility, to see doctor or nurse)*	☐☐ ☐☐ ☐☐ ☐☐ Minutes Hours Days Week	
7. Was CT scan or MRI done to confirm diagnosis?	Yes 1 No 2 Don't know 999	☐

8. Current modified-Rankin scale score for the participant? *(Select number from the options given)* .	a) Normal function b) No significant disability- able to carry out all previous usual activates c) Slight disability- unable to carry out all previous usual activates but able to attend to own bodily needs without assistance d) Moderate disability- requiting some help for bodily needs and/or unable to walk without assistance of a physical device e) Severe disability- unable to attend to bodily needs without assistance and/ or unable to walk without assistance f) Very severe disability- bedridden, incontinent and requiring constant nursing care and attention	1 2 3 4 5 6	☐
9. Do you have any supporting medical document?	Yes 1 No 2 Refused 888		☐ If "2" or "3" skip to the main questionnaire
9a. Please make digital copy of available supporting documents of the participant. Yes 1 No 2	a) Discharge report b) Consultation notes c) Prescription d) ECG e) Lab Reports f) CT-Scan g) MRI h) Other If other, specify_____		☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

APPENDIX C.1 | *Verbal Autopsy Form (Pure)*

NOTE: For those who answered "Deceased" as to why the participants did not agree to be interviewed in the **Participant Information Section** of this questionnaire.

PART A		
1. Did the proxy ready to share VA information?	Yes1 No2	☐ If "2" go to short questionnaire
2. Does the family member/ relative know the exact date of death	Yes1 No2 Don't know 999	☐ If "999" skip to Q4
3. Date of death of participant?	☐☐☐☐ Year ☐☐ Month	
Details of the respondent		
4. What is the relation of respondent to the deceased participant?	Spouse 1 Son/Daughter 2 Sibling 3 Mother/Father 4 Mother-in-law/Father-in-law 5 Grandchild 6 Daughter-in-law/Son-in-law 7 Friend 8 Neighbour 9 Other 777	☐ If other; Specify_____
4a. What is the age of respondent?	☐☐ Years	
4b. Gender of the respondent	Male 1 Female 2	☐
4c. Did the respondent live with the deceased during the events that lead to death?	Yes 1 No 2	☐
5. Was the death witnessed?	Yes, By Respondent 1 No 2 Yes, By others 3	☐ If other; Specify_____
6. What was the place of death?	Home 1 Hospital 2 Other place 3 Don't know 999	☐ If other; Specify_____
7. Was the death registered?	Yes 1 No 2 Don't know 999	☐
8. Did any of the given events/ new diagnoses occur since the last follow-up, up to and including date of death? (Yes=1; No=2; Don't know=999)	a) MI/ Heart Attack b) Stroke c) Angina d) Heart Failure e) Cancer f) TB g) HIV/ AIDS h) Malaria i) COPD/Chronic Bronchitis/ Emphysema	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

	j) Asthma k) Pneumonia l) Renal/Kidney (Dialysis/transplant)	☐ ☐ ☐ ☐
9. Since the last follow-up, up to time of death, did the participant have any injuries that were serious enough to limit normal activities for at least one day?	Yes 1 No 2 Don't know 999	☐
10. Was the participant hospitalized for any other reason(s) aside from the events/diagnoses listed in Q8 and Q9 above, from last visit up to time of death?	Yes 1 No 2 Don't know 999	☐
11. Did the participant have diabetes?	Yes 1 No 2 Don't know 999	☐ If "1" go to Q11a, If "2" or "999" go to Q12
11a. Was it newly diagnosed since last follow-up?	Yes 1 No 2	☐ If "1" go to Q11b, if "2" go to Q12
11b Does the respondent, know the exact date of original diagnosis of diabetes?	Yes 1 No 2 Don't know 999	☐ If "1" or "2" go to Q11c, if "999" go to Q12
11c. What was the date of original diagnosis?	☐☐☐☐ ☐☐ Year Month	
12. Do you know the cause of death?	Yes 1 No 2	☐ If "1" go to Q13, if "2" go to Q14
13. What was the cause of death? (Cardiovascular) **(Enter 1 for Primary Cause (choose ONE only) AND enter 2 for all other contributing causes (choose ALL that apply)** ***Note**: 1 = Primary Cause; 2 = contributing cause; 555 for not applicable.*	a) MI/ Heart Attack b) Stroke c) Heart Failure d) Other Heart Disease	☐ ☐ ☐ ☐ If other, specify & complete verbal autopsy form_____

13a. What was the cause of death? (Non-Cardiovascular) **(Enter 1 for Primary Cause (choose ONE only) AND enter 2 for all other contributing causes (choose ALL that apply)** ***Note**: 1 = Primary Cause; 2 = contributing cause; 555 for not applicable.*	e) Cancer f) Asthma g) COPD h) TB i) Pneumonia j) HIV/AIDS k) Malaria l) Injury/Accident m) Kidney n) Typhoid o) Diarrhoea & Gastroenteritis/ Dysentery p) related to pregnancy q) Liver r) COVID-19 s) Other If other, specify & complete verbal autopsy form _____	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
14. Is there any medical/supporting documentation available for the deceased?	Yes 1 No 2 Yes, refused 3	☐ If "1" goto Q14a, if "2" or "3" complete verbal autopsy form
14a. Please make digital copy of available supporting documents for the participant. (Yes=1 No=2)	Discharge report Narrative Summary Physician /Consult notes Prescription List Diagnostic test results Histology/Pathology report Operative/Surgical Report Laboratory test results Electrocardiogram (ECG) Death certificate Autopsy/Post-mortem report Sputum test results Biopsy Echo Report Test results CT Scan MRI Spirometry report/ Lung function report Other	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ If other, pls specify _____
Part B | Verbal Autopsy Questionnaire		
1. How did this person die? (Write an account of final illness in respondent's own words)		

Part C | Context and history of previously known medical conditions:		
The following questions concern the contexts and previously known medical conditions the deceased had; and the signs and symptoms that the deceased had/showed when he/she was ill. Some of these questions may not appear to be directly related to his/her death but they will help us to get a clear picture of all possible symptoms prior to death.		
1. Did he/she die suddenly?	Yes 1 No 2 Don't know 999	☐ If "2" or "999" go to Q2
1a. Was sudden death witnessed?	Yes 1 No 2	☐
2. Was he/she well during the 12 hours prior to death?	Yes 1 No 2 Don't know 999	☐ If "1" go to Q3
2a How long was he/she ill before he/she died?	<12 hours 1 12 hours but < 24 hours (1day) 2 2-7 days 3 >1 week 4 Don't know 999	☐ If "3" goto 2b, if "4" go to 2c

2b. Mention the number of days	☐☐ Number of Days	
2c. Mention the number of Weeks	☐☐ Number of Weeks	
Symptoms noted during the final illness		
3. Did he/she have any breathing problems?	Yes 1 No 2 Don't know 999	☐ If "2" or "999" go to Q4
3a. Did he/she have fast breathing?	Yes 1 No 2 Don't know 999	☐ If "1" go to 3b, if "2" or "999" go to 3c
3b. How long he/she had fast breathing?	☐☐ Number of Days ☐☐ Number of Weeks	
3c. Did he/she have breathlessness?	Yes 1 No 2 Don't know 999	☐ If "1" go to Q3d, if "2" or "999" go to Q4
3d. How long he/she had breathlessness?	☐☐ Number of Days ☐☐ Number of Weeks	
3e. Was he/she unable to carry out daily routines due to breathlessness	Yes 1 No 2 Don't know 999	☐
3f. Did he/she have breathlessness on exertion?	Yes 1 No 2 Don't know 999	☐ If "2" or "999" go to Q4
3g. If yes, when did she/he have breathlessness on exertion?	On vigorous exertion (climbing stairs) 1 On moderate exertion (rapid walking) 2 On slight exertion 3 At rest 4 Don't Know 999	☐
3h. Was there breathlessness at night causing the person to wake up after?	Yes 1 No 2 Don't know 999	☐
4. Did he/she have wheezing/whistling in the chest?	Yes 1 No 2 Don't know 999	☐
5. Did he/she have chronic cough lasting 3 months in the past 2 years?	Yes 1 No 2 Don't know 999	☐
6. Did he/she have feet swollen?	Yes 1 No 2 Don't know 999	☐
7. Was he/she unconscious for more than 24 hours?	Yes 1 No 2 Don't know 999	☐ If "2" or "999" go to Q8
7a. Did the unconsciousness start suddenly/quickly (at least within a single day)?	Yes 1 No 2 Don't know 999	☐
8. Did he/she have noticeable weight loss?	Yes 1 No 2 Don't know 999	☐
9. Did he/she drink a lot more water than usual?	Yes 1 No 2 Don't know 999	☐
10. Did he/she have urine problems?	Yes 1 No 2 Don't know 999	☐ If "2" or "999" go to Q11

10a.Did he/she pass no urine at all?	Yes 1 No 2 Don't know 999	☐
Symptoms noted during the month preceding death		
11. Did he/she have chest pain?	Yes 1 No 2 Don't know 999	☐ If "2" or "999" go to Q12
11a. How long did the chest pain last?	< 24 hours 1 > 24 hours 2	☐
11b. Where was the chest pain located?	Central chest 1 Left chest 2 Right chest 3 Other 4 Don't Know 999	☐ If other, specify_____
11c. Was the chest pain/discomfort accompanied by or followed by: (1=Yes, 2=No, 999=Don't know)	i. Sweating ii. Unconsciousness iii. Vomiting iv. Others **If others, pls specify** _____	☐ ☐ ☐ ☐
11d. Was there chest pain/discomfort on exertion?	Yes 1 No 2 Don't know 999	☐ If "2" or "999" go to Q12
11e. If yes, when did she/he feel the chest pain/discomfort on exertion?	On vigorous exertion (climbing stairs) 1 On moderate exertion (rapid walking) 2 On slight exertion 3 At rest 4 Don't Know 999	☐
12. Did he/she have paralysis of one or both sides of the body?	Yes, one side 1 No 2 Yes, both sides 3 Don't Know 999	☐ If "1" or "3" go to 12a else go to 13
12a. If yes, was the paralysis accompanied or followed by a sudden loss of consciousness?	Yes 1 No 2 Don't know 999	☐
13. Was there a pre-existing heart problem at any time or was heart disease diagnosed as cause of death?	Yes 1 No 2 Don't know 999	☐ If "1" go to 13a else go to 14
13a. If yes, what was the diagnosis (record verbatim)? _____		

14. Were any of the following listed as the diagnosis - verbally or on medical certificate? (1=Yes, 2=No, 999= Don't know)	a) Heart attack b) Angina c) Heart failure d) Heartbeat abnormality (irregular heart beat) e) Heart valve defect f) Birth defect of heart or blood vessels g) Fluid around the heart h) Related to heart surgery i) Other	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ If other, specify_____

APPENDIX C.2 | *BP and Anthropometry Form*

Participant ID		**Household ID**	
CEB Code		**Date of interview** (DD/MM/YY)	
Interviewer ID		**Cohort**	
Centre Code			

I. BLOOD PRESSURE AND PULSE RATE

Instrument ID:

Type of Measurement	1st Reading	2nd Reading	Difference between 1st and 2nd	Tolerance	3rd Reading (if necessary)
Systolic BP				**10 mm Hg**	
Diastolic BP				**6 mm Hg**	
Pulse rate					

II. ANTHROPOMETRIC MEASUREMENTS

1. Height (cm)	**Instrument ID**	**2. Weight (Kg)**	**Instrument ID**
Standing Height (cm)	.	**Weight (Kg)**	

III. BODY CIRCUMFERENCE (cm)

Tape ID:

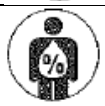
1. Waist (cm)	Clothing (√)	2. Hip (cm)	Clothing (√)
.	None Light Heavy		None Light Heavy

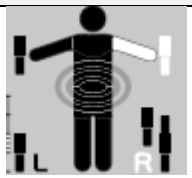
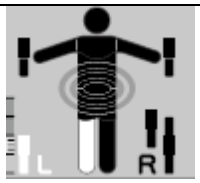
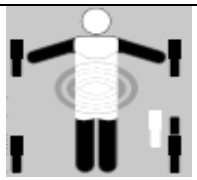
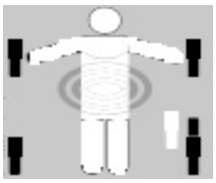
Comments (if any): _____

_____

APPENDIX C.3 | *Tanita Form*

Participant ID		**Household ID**	
CEB Code		**Date of interview** (DD/MM/YY)	
Interviewer ID		**Cohort**	
Centre Code			

S No.	Measures	Symbols	Reading
1.	Weight (Kg)		
2.	Age (Years)		
3.	Gender (Male/Female/Athlete)		
4.	Height (cm)		
5.	Body Fat (%)		
6.	Muscle Mass (Kg)		
7.	Bone Mass (Kg)		
8.	Body Mass Index (BMI)	 BMI	
9.	Daily Calorie Intake (DCI)	 DCI	
10.	Metabolic Age (Years)		
11.	Body Water (%)		
12.	Visceral Fat		

S No.	Measures	Symbols	Reading
13.	Right Arm		
14.	Left Arm		
15.	Right Leg		
16.	Left Leg		
17.	Rest of the body		
18.	Whole body		
Notes (If any):			

APPENDIX C.4 | *Hand Grip Form*

Measuring Hand Grip Strength using Hand Dynamometer

Participant ID	☐☐☐☐☐☐	**Household ID**	☐☐☐☐☐☐
CEB Code	☐☐☐	**Date of interview** (DD/MM/YY)	☐☐☐☐☐☐
Interviewer ID	☐☐☐	**Cohort**	☐
Centre Code	☐	**Instrument ID**	☐☐

***NOTE**: Ask participant these questions before starting hand grip measurement.*

1.1 Which is your dominant hand?	Right 1 Left 2 Use both hands equally 3	☐
1.2 How much effort did the participant give to this test?	Gave full effort 1 Was prevented from giving full effort by illness, pain or other symptoms or discomforts 2 Did not appear to give full effort, but no obvious reson for this 3	☐

		Right hand	**Left hand**
1.3 Do you have any of the following problems withyour hands? * (Yes=1; No=2) ***NOTE**: If any of above disease is present in bothhands, don't do grip strength measurement.*	Rheumatoid Arthritis/Joint pain/ stiffness	☐	☐
	Deformity (amputation or birth defect in hands)	☐	☐
	Any hand/wrist surgeryin past 3 months	☐	☐
	Any paralysis/nerve problem in extremity	☐	☐
	Any fracture/open wound/injury	☐	☐
	Any other problem, please specify ----------	☐	☐ ----------
		Right hand	**Left hand**
1.4 Note the three readings obtained by the dynamometer? (In Kg)	In Kg	☐☐☐	☐☐☐
	In Kg	☐☐☐	☐☐☐
	In Kg	☐☐☐	☐☐☐

APPENDIX C.5 | *Short Questionnaire Form*

Those who refused to participate

Participant ID	☐☐☐☐☐☐	**Household ID**	☐☐☐☐☐☐
CEB Code	☐☐☐	**Date of interview** (DD/MM/YY)	☐☐☐☐☐☐
Interviewer ID	☐☐☐	**Cohort**	☐
Centre Code	☐		

Part 1: Response and contact of the participant

1. Does the participant agree to be interviewed?	***[Yes =1; No =2]***	☐ If '**2**', go to Q-4
2. If **YES**, what is the present address	1- Same as last fup 2- Changed	☐ *If '**1**' go to question-6*
3. If changed, note the current address **[If filled, please skip to Part 1A]**:		
4. If **NO**, what is the reason for non-response?	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 "8" please specify"** _____

- **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**

5. If "**Refused",** reasons for refusal	1- Not able to give time 2- Interviews are lengthy 3- Not interested in providing blood sample 4- Too much blood drawn 5- Not satisfied with the lab report 6- Need more medical attention/medicine 7- Don't see any benefit in participating in the study 8- Don't feel secure 9- Son't want to give any reason 10- Medical facility is available 11- Others **If others, please specify** _____ _____	**Write all the options applicable** ☐ ☐ ☐ ☐ ☐ ☐
Part 1A:- Details of contacts		
6. Name of the 1st contact		
Address of 1st contact		
Telephone number of 1st contact		
7. Name of the 2nd contact		
Address of 2nd contact		
Telephone number of 2nd contact		
8. Name of the Home Town contact		
Address of Home Town contact		
Telephone number of Home Town contact		

Section- 1: Response and survival status		
1. Who is responding to this form?	CARRS participant = 1 Proxy = 2 (Proxy: details are collected from different person)	☐ **If " CARRS partcipant=1", go to question-3**
1a. If Proxy, what is the relation with the participant?	Family Member =1 Friend =2 Neighbor =3 Other =4	☐ **"If '4' then specify" ----------**
2. What is the participant's survival status?	Alive=1 Deceased=2 Unknown=3	☐ **"If '2', go to section-3"** **"If '3', make notes in comment section"**
3. Does the participant or proxy, ready to provide few information?	Yes=1 No=2	☐ **" If '2' end the questionnaire and thanks to interviewee"**
4. Mode of Interview?	In person =1 Telephonic =2	☐
Comments:		

Section 2: Information on cardio metabolic events						
1. Since the last **CARRS** visit, has the participant told by a doctor that s/he had any following disease? **[Yes=1; No=2; Don't know=3]**	**Myocardial infarction (MI)**	**Angina**	**Heart failure**	**Stroke**	**Diabetes**	**Hypertension**
	☐	☐	☐	☐	☐	☐
"If 'yes' any of the choice in Q. No.1, then go to 1a. otherwise go to Q no.2"						
1a. Is the date of event/ diagnosis known? **[Yes=1; No=2; Don't know=3]**	☐	☐	☐	☐	☐	☐
1b. If **"Yes"**	**When was the most recent event?**				**When was the diagnosis made?**	
	☐☐ ☐☐ **(MM) (YY)**	☐☐ ☐☐ **(MM) (YY)**	☐☐ ☐☐ **(MM) (YY)**	☐☐ ☐☐ **(MM) (YY)**	☐☐ ☐☐ **(MM) (YY)**	☐☐ ☐☐ **(MM) (YY)**
2. Since the last CARRS visit, has the participant undergone the following procedure/s? **[Yes=1; No=2; Don't know=3]**	**Coronary angioplasty or stent**	**Coronary bypass graft**	**Renal Dialysis**	**Kidney transplant**	**Amputation of lower limb**	
	☐	☐	☐	☐	☐	

"If 'yes' any of the choice in Q. No.2, then go to 2a. otherwise go to Section:3"					
2a. Is the date of procedure/s known? **[Yes=1; No=2; Don't know=3]**	☐	☐	☐	☐	☐
2b. If **"Yes"**	**When was participant's latest procedure?**				
	☐☐ ☐☐ **(MM) (YY)**	☐☐ ☐☐ **(MM) (YY)**	☐☐ ☐☐ **(MM) (YY)**	☐☐ ☐☐ **(MM) (YY)**	☐☐ ☐☐ **(MM) (YY)**

Section 3: Information in case of death		
1. If deceased, is the date of participant's death known?	***[Yes =1; No =2]***	**"If '2', go to Question-3"**
2. If yes, what is the date of death?	If intervewee does not recall the exact day please write Month **(MM)** & Year **(YY)** and write "**99"** in Date **(DD)** box.	☐☐ ☐☐ ☐☐ **(DD) (MM) (YY)**
3. Does the interviewee agree to provide details about the participant's death?	***[Yes =1; No =2]***	☐ If **'1'** end the questionnaire and complete "**verbal autopsy"** form" " If **'2'** end the questionnaire and thanks to interviewee"