CARRS SURVEILLANCE STUDY: COHORT-1

4th follow up questionnaire

Cluster ID ☐☐☐☐☐☐☐☐☐☐			Household ID ☐☐☐☐☐☐
Follow-up ID ☐☐☐	Interviewer ID ☐☐☐☐		PID ☐☐☐☐☐
Date of interview: ☐☐☐☐☐☐ DD/ MM/ YY			Start Time (Hr:min) ☐☐ ☐☐ HR MIN

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	Same as baseline survey/follow up 1, 2 & 3 1 Changed 2	☐ *If '**1**' go to question-6*
3. If changed, note the current address:		

4. If **NO**, what is the reason for non-response?	Shifted not traceable **1** Shifted, traceable but not interested **2** Shifted but not approachable/out of area range **3** Hard refusal **4** Soft refusal **5** Deceased **6** Could not complete this survey and will available for next year follow-up **7** Others **8**	☐ 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:		*Yes=1; No=2*
	A. Not able to give time	☐
	B. Interviews are lengthy	☐
	C. Not interested in providing blood sample	☐
	D. Too much blood drawn	☐
	E. Not satisfied with the lab report	☐
	F. Need more medical attention/medicines	☐
	G. Do not see any benefit in participating in the study	☐
	H. Do not feel secure	☐
	I. Do not want to give any reason	☐
	J. Others	☐
	If others: Please specify in detail: _____ _____ _____ _____ _____ _____	

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	

CARRS SURVEILLANCE STUDY: COHORT-1

4th follow up questionnaire- Part II

Household ID :-	Participant ID :-
CEB Code :-	Interviewer ID:-
Date of Interview:- D D M M Y Y	Start Time:- Hour Minutes

1.1 For men, relationship with the female participant (Ask only to male participant)	Not applicable (particpant is female) 0 Husband 1 Father-in-law 2 Son 3 Father 4 Grand father 5 Brother-in-law (husband's brother) 6 Brother-in-law (sister's husband) 7 Son-in-law 8 Brother 9 Cousin 10 No female participant is selected 11 Female participant was adopted into the family 12 Male participant was adopted into the family 13 Others, specify 14	If others (option 14), then specify ----------
1.2 What is your marital status ?	Single 1 Married 2 Widow/Widower 3 Separated/Divorced 4 Others 5	If others (option 5), then specify ----------

PART 1B :- SOCIO-ECONOMIC DETAILS

1.3 Number of years of formal education* **The total number of years the participant spent in any educational institution (schools, colleges, religious schools etc.)*		
1.4 Educational status (highest attained degree) ** A person who can both read and write with understanding in any language without any formal education or passed any minimum educational standard.* *** A person who can neither read nor write or can only read but cannot write in any language*	Professional degree/post graduate 1 Graduate (B.A/B.Sc/B.Com/Diploma) 2 Secondary School /Intermediary (ITI course ,class XII/X or Intermediate) 3 High school (class V to IX) 4 Primary School (up to Class IV) 5 *Literate, no formal education 6 **Illiterate 7 Others 8	If others (option 8), then specify _____

1.5 What is your employment status?	Employed 1 Student 2 Housewife 3 Retired 4 Un-employed 5 Others 6	If other (option 6), then specify _____
1.6 If ***"Employed"***, *what* is your current occupation? *[Use nearest applicable employment codes given below]*		Please mention _____

Coding list for employment (for Q1.6)

Professional, big business ,landlord (> 10 acre) , university teacher, class 1IAS/services officer, lawyer **1**

Trained, clerical, medium business owner, middle level farmer (2-10 acre) , teacher, maintenance (in-charge), personnel manager **2**
Skilled manual laborer, small business owner, small farmer (<1 acre) **3**
Semi-skilled manual laborer, marginal land owner, rickshaw driver, army jawan, carpenter, fitter **4**
Unskilled manual laborer, landless laborer **5**

1.7 Have you been involved in any other occupation during past ten years?	Yes 1 No 2	If "2" go to Q.1.9
1.8 If ***"Yes"***, *what* was your previous occupation? *[Use nearest applicable employment codes given below]*		Please mention _____

Coding list for employment (for Q1.8)

Professional, big business ,landlord (> 10 acre) , university teacher, class 1IAS/services officer, lawyer **1**

Trained, clerical, medium business owner, middle level farmer (2-10 acre) , teacher, maintenance (in-charge), personnel manager **2**
Skilled manual laborer, small business owner, small farmer (<1 acre) **3**
Semi-skilled manual laborer, marginal land owner, rickshaw driver, army jawan, carpenter, fitter **4**
Unskilled manual laborer, landless laborer **5**

1.9 What is your total household income per month? **[Please include income from all member who contribute to the household]**	<3000 1 3000-10,000 2 10,001-20,000 3 20,001-30,000 4 30,001-40,000 5 40,001-50,000 6 >50,000 7 Refused 8 Don't know 9	
1.10 Do you have a separate room for cooking (Kitchen)?	Yes 1 No 2	
1.11 What is the fuel used for cooking? **[If more than one source is used then note the source that is most commonly used]**	Coal/charcoal/kerosene 1 Induction/Electricity/gas(LPG)/solar/CNG(IGL) 2 Wood/dung 3 Others 4	If others (option 4), then sepcify _____

1.12 What is the source of drinking water used at home? **[If more than one source is used then note the source that is most commonly used]**	Public source 1 Private source(Shared) 2 Private source(Own) 3 Bottled water 4 Purified tap water 5 Others 6	If others (option 6), then sepcify _____
1.13 What is the toilet facility you use?	Public toilet 1 Shared toilet 2 Own flush toilet 3 Others 4	If others (option 4), then sepcify _____
1.14 Which of the following do you own? *[Yes=1;No=2]*	Television Refrigerator Washing machine Microwave/OTG Mixer-grinder Mobile phone DVD player Computer/Laptop Car Motor Cycle/ Scooter Bicycle	

SECTION 2 :- TOBACCO and ALCOHOL CONSUMPTION AND PHYSICAL ACTIVITY

PART 2A:- TOBACCO AND ALCOHOL USE

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

PART 2B :- PHYSICAL ACTIVITY

Next, I am going to ask you about the time you spend doing different types of physical activity in a typical week. Please answer these questions even if you do not consider yourself to be a physically active person.
Think first about the time you spend doing work. Think of work as the things that you have to do such as paid or unpaid work, study/training, household chores, harvesting food/crops, fishing, seeking employment. In answering the following questions 'vigorous-intensity activities' are activities that require hard physical effort and cause large increases in breathing or heart rate, 'moderate-intensity activities' are activities that require moderate physical effort and cause small increases in breathing or heart rate.

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

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

2.15	In a **typical week (7 days)**, on how many days do you do vigorous-intensity sports, fitness or recreational (*leisure*) activities?	No. of days	☐
2.16	How much time do you spend doing vigorous-intensity sports, fitness or recreational activities on a typical day? Ask the participant to think of a typical day he/she can recall easily in which he/she engaged in recreational vigorous-intensity activities. Think of one day you can recall easily. Consider the total amount of time doing vigorous recreational activities for periods of 10 minutes or more. Probe very high responses (over 4 hrs).	Hours : Minutes	☐☐ ☐☐ Hours : Minutes
2.17	Do you do any moderate-intensity sports, fitness or recreational *(leisure)* activities that causes a small increase in breathing or heart rate such as brisk walking, *cycling, swimming, volleyball* for at least 10 minutes continuously? ***(USE SHOWCARD)*** Activities are regarded as moderate intensity if they cause a small increase in breathing and/or heart rate. *[Cycling, jogging, dancing, horse-riding, yoga, low-impact aerobics, cricket]*	Yes 1 No 2	☐ **If "2", go to Q.2.20**
2.18	In a **typical week (7 days)**, on how many days do you do moderate-intensity sports, fitness or recreational (*leisure*) activities?	No. of days	☐
2.19	How much time do you spend doing moderate-intensity sports, fitness or recreational (*leisure*) activities on a **typical day**? Ask the participant to think of a typical day he/she can recall easily in which he/she engaged in recreational moderate-intensity activities. Think of one day you can recall easily. Consider the total amount of time doing moderate recreational activities for periods of 10 minutes or more. Probe very high responses (over 4 hrs).	Hours : Minutes	☐☐ ☐☐ Hours : Minutes

2B-IV: **- Sedentary behavior**

The following question is about sitting or reclining at work, at home, getting to and from places, or with friends including time spent [sitting at a desk, sitting with friends, travelling in car, bus, train, reading, playing cards or watching television], but **do not include time spent sleeping**.
(USE SHOWCARD)

2.20	How much time do you usually spend sitting or reclining on a **typical day**?	Hours : Minutes	☐☐ ☐☐ Hours : Minutes
2.21	How many hours/ minutes do you spend sitting/reclining in each of the following on a **typical day**?	A. At work at the desk	☐☐ ☐☐ Hours : Minutes
		B. In class during lectures	☐☐ ☐☐ Hours : Minutes
		C. During travel (driving, traffic jams, bus, car, train, metro)	☐☐ ☐☐ Hours : Minutes
		AT HOME	

		D. During watching television	☐☐ Hours : ☐☐ Minutes
		E. In front of a computer	☐☐ Hours : ☐☐ Minutes
		F. Any other (chatting, playing cards etc.)	☐☐ Hours : ☐☐ Minutes
2.22	For how long you stand in a typical day? **(Calculate only if the standing is more than 10 minutes continuously)**	Hours : Minutes	☐☐ Hours : ☐☐ Minutes
2.23	Is there a park/open space/garden/children play ground near your house?	Yes 1 No 2	☐ If 2, skip to Section 3
2.24	If yes, in a typical week do you use the park/ open space/garden/ children playground?	Yes 1 No 2	☐ If 2, skip to Section 3
2.25	If yes, what do you use it for?	A. Walking/Yoga/ Jogging/Sports/ other exercises	**Yes=1; No=2** ☐
		B. Sitting/ Socializing/ Meditation/ playing with or supervising kids	☐
		Others	☐ _____specify

SECTION– 3:MEDICAL HISTORY (CARDIO METABOLIC DISEASES AND THEIR RISK FACTORS)

PART 3A: DISEASE SPECIFIC QUESTIONS

3A-I: Fill this section if the answer for high blood pressure/ high blood sugar/high blood cholesterol is "YES" in PART 3A-I, Q.3.1. *If the answer is* ***'YES'*** *to any of the choices in Q. 3.1, then go to Q.3.2.* ***'OTHERWISE'*** *skip the entire section and go to 3A-II*

**Exclude pregnancy induced Hypertension and High Blood Sugar*

3A-I: HYPERTENSION (High Blood Pressure)/DIABETES (High Blood Sugar)/ HYPERLIPIDEMIA (High Blood Cholesterol)

	Hypertension (High Blood Pressure)*	Diabetes (High Blood Sugar)*	Hyperlipidemia (High Blood Cholesterol)
3.1 Have you EVER been told by a doctor that you have any of the following diseases? *[Yes =1; No =2; Don't know=3]*	☐	☐	☐
3.2 **SINCE HOW MANY YEARS** have you had Hypertension/ Diabetes/ Hyperlipidemia?	Duration in Years /Month Years ☐☐ Months ☐☐	Duration in Years /Month Years ☐☐ Months ☐☐	Duration in Years /Month Years ☐☐ Months ☐☐
3.3 What treatment are you taking for it currently? **[Yes=1; No=2]**			
Prescribed dietary modification	☐	☐	☐
Prescribed physical exercise	☐	☐	☐
Traditional medicine/Therapy* other than yoga	☐	☐	☐
Allopathic drugs(English/modern)	☐	☐	☐
Yoga	☐	☐	☐

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

3A-II: HEART DISEASE

3.4 Have you **EVER** been told by a doctor that you have heart disease? **[Yes=1 ; No=2*; Don't know=3*]**	☐ **If "2" or "3" skip to *3A-III***	
3.5 What did the doctor say it was? **[Yes=1; No=2; Don't know/Not sure=3]**	A. Heart attack B. Angina C. Heart failure D. Valve disease E. Hole in the heart F. Not informed about the nature of the problem G. Others	☐ ☐ ☐ ☐ ☐ ☐ ☐ If "1" for other, please specify _____

If "1" for heart attack then fill the following questions otherwise skip to Q3.14

3.6 If heart attack, how many attacks you have had till now?	☐☐		
	First event (Heart attack)	**Second event (Heart attack)**	**Third event (Heart attack)**
3.7 Date of heart attack	☐☐ ☐☐ Month Year	☐☐ ☐☐ Month Year	☐☐ ☐☐ Month Year
3.8 What symptoms did you have during this event? A. Chest pain/ discomfort >20 minutes B. Pain radiating to arm, shoulder or neck C. Sweating or vomiting D. Others	**[Yes=1; No=2; Not sure=3]** ☐ ☐ ☐ ☐ If others please specify _____	**[Yes=1; No=2; Not sure=3]** ☐ ☐ ☐ ☐ If others please specify _____	**[Yes=1; No=2; Not sure=3]** ☐ ☐ ☐ ☐ If others please specify _____
3.9 How long these symptoms were present before you met doctor?	☐☐ ☐☐ ☐☐ Weeks Days Hours	☐☐ ☐☐ ☐☐ Weeks Days Hours	☐☐ ☐☐ ☐☐ Weeks Days Hours
3.10 Were you hospitalized for this event? **[Yes=1; No=2]**	☐	☐	☐
	If yes, go to Q3.11 otherwise skip to Q3.12		
3.11 If hospitalized for this event, what procedure did they do in the hospital? Angioplasty (Stent)=1 Coronary Artery bypass surgery (Bypass) =2 Thrombolytic therapy =3 Only medicines =4 Others=5	☐ If others please specify _____	☐ If others please specify _____	☐ If others please specify _____
	If Q3.11 is filled then skip to Q3.13		
3.12 If **not** hospitalized for this event, where did you take treatment? Visited allopathic doctor and took treatment as outpatient=1 Visited Ayurveda/homeopathic/other traditional healers =2 Others=3	☐ If others please specify _____	☐ If others please specify _____	☐ If others please specify _____

3.13 Ask the participant whether they have medical records related to the events and current medication and treatment. If so, please take pictures of every page of the record. A. Discharge report B. Consult notes C. Prescription D. ECG E. Lab reports F. Other	[Yes=1; No=2] ☐ ☐ ☐ ☐ ☐ ☐ If others please specify _____	[Yes=1; No=2] ☐ ☐ ☐ ☐ ☐ ☐ If others please specify _____	[Yes=1; No=2] ☐ ☐ ☐ ☐ ☐ ☐ If others please specify _____
3.14 Are you taking any treatment for heart disease currently? [Yes=1; No=2]	A. Allopathic drugs (English /modern) B. Traditional medicine (other than Yoga) C. Yoga D. Others		☐ ☐ ☐ ☐ If others please specify _____
3.15 **For all participants:** Have you ever undergone coronary angioplasty or stent? (This is a procedure to put stent in the heart blood vessels to destroy clots)	Yes 1 No 2		☐ If "2" skip to 3A-III
3.16 If yes, when did you have latest procedure?	☐☐ Months ☐☐ Years		
3A-III: STROKE (Paralytic attack)			
3.17 Have you **EVER** been told by a doctor that you have stroke (Paralytic attack)? [Yes=1 ; No=2; *Don't know=3*]	☐ If "2" or "3" skip to *3A-IIIa*		
3.18 If yes, how many times?	Number of times ☐☐		
	First Stroke	Second Stroke	Third Stroke
3.19 Date of the stroke	☐☐ Month ☐☐ Year	☐☐ Month ☐☐ Year	☐☐ Month ☐☐ Year

3.20 What symptoms did you experience? A. Did you become unconscious or drowsy? B. Was there loss of vision? C. Was there weakness in face or limbs? D. Was there weakness in on limb/half of the body? E. Was there difficulty in speaking? F. Was there disturbances of balance or walking? G. Was there trauma to the head or neck?	[Yes= 1; No= 2; Not sure/ Don't remember=3]	[Yes= 1; No= 2; Not sure/ Don't remember=3]	[Yes= 1; No= 2; Not sure/ Don't remember=3]
	If "2" or "3" in all the boxes skip to Q3.22		
3.21Was duration of any symptoms > 24 hours?	[Yes= 1; No= 2; Not sure/ Don't remember=3]	[Yes= 1; No= 2; Not sure/ Don't remember=3]	[Yes= 1; No= 2; Not sure/ Don't remember=3]
3.22Who diagnosed the stroke? MBBS doctor 1 Ayurveda/homeopathic/ traditional healer 2 Others 3 Not sure/ Don't remember 4	If others please specify _____	If others please specify _____	If others please specify _____
3.23Were you hospitalized for this stroke?	[Yes= 1; No= 2; Not sure/ Don't remember=3]	[Yes= 1; No= 2; Not sure/ Don't remember=3]	[Yes= 1; No= 2; Not sure/ Don't remember=3]
	If "2" skip to Q3.25 and if "3" skip to Q3.26		
3.24If hospitalized for this stroke, was CT scan or MRI done?	[Yes= 1; No= 2; Not sure/ Don't remember=3]	[Yes= 1; No= 2; Not sure/ Don't remember=3]	[Yes= 1; No= 2; Not sure/ Don't remember=3]
3.25 If not hospitalized, why? Visited allopathic doctor and took treatment as outpatient 1 Visited Ayurveda/homeopathic /other traditional healers 2 Others 3 Not sure/ Don't remember 4	If others please specify _____	If others please specify _____	If others please specify _____

3.26 Ask the participant whether they have medical records related to the events and current medication & treatment. If so, please take pictures of every page of the record. A. Discharge report B. Consult notes C. Prescription D. ECG E. CT F. MRI G. Lab reports H. Other	[Yes=1; No=2] ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ If others please specify _____	[Yes=1; No=2] ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ If others please specify _____	[Yes=1; No=2] ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ If others please specify _____
3.27Do you have a residual disability in any part of the body?	Yes 1 No 2		☐ If "2" skip to Q.3.29
3.28If **'YES'**, does it involve the following? *[Yes=1; No=2]* A. Paralysis of leg/foot B. Paralysis of arm/hand C. Weakness of leg/foot D. Weakness of arm/hand E. Defect of speech F. Defect of vision G. Urinary incontinence H. Any other weakness			☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ If other, please specify _____
3.29Are you **advised** to continue any medication after your paralytic attack?	Yes 1 No 2		☐

3A-IIIA : Stroke free status (All stroke free participants) {Fill only if the answer to Q3.18 is 2 or 3}.

Questionnaire for Verifying Stroke-Free Status (QVSFS – Jones et al)

Codes: Yes=1 No=2 Not sure/Don't know=3

3.30 Were you ever told by a physician that you had a TIA, ministroke, or transient ischemic attack?	☐
3.31 Have you ever had sudden painless weakness on one side of your body?	☐
3.32 Have you ever had sudden numbness or a dead feeling on one side of your body?	☐
3.33 Have you ever had sudden painless loss of vision in one or both eyes?	☐
3.34 Have you ever suddenly lost one half of your vision?	☐
3.35 Have you ever suddenly lost the ability to understand what people are saying?	☐
3.36 Have you ever suddenly lost the ability to express yourself verbally or in writing?	☐

3A-IV: KIDNEY

3.37 Have you EVER been told by a doctor that you have:		**Yes=1; No=2**	If YES, since how long? (**For kidney stones: most recent**)
	A. Kidney stone	☐	YY ☐☐ MM ☐☐
	B. Kidney disease	☐	☐☐ ☐☐
	C. Kidney failure	☐	☐☐ ☐☐
	If all the options in Q.3.37 is filled with "2" skip to "3A-V"		
3.38 If **YES** for kidney stones, what treatment was received?	Only medication 1 Surgery 2 No treatment 3 Others 4		☐ **If others (Option 4), then specify** _____
3.39 If **YES**, for kidney disease or kidney failure **[Yes =1; No =2]**	A. Have you ever undergone dialysis? B. Have you ever undergone kidney transplant?		☐ ☐

3A-V: CANCER

3.40 Have you **EVER** been told by a doctor that you have cancer? **[Yes=1 ; No=2; *Don't know=3*]**		☐ **If "2" or "3" skip to "PART 3A-VA"**

3.41 If yes, which site	How was it detected?	At what stage it was diagnosed?	When were you diagnosed with it? Year of diagnosis
a. Site 1 ☐	☐	☐	☐☐☐☐
b. Site 2 ☐	☐	☐	☐☐☐☐
c. Site 3 ☐	☐	☐	☐☐☐☐
d. Site 4 ☐	☐	☐	☐☐☐☐
e. Site 5 ☐	☐	☐	☐☐☐☐
If "14", then specify _____			
Codes			
Oral =1 ; Esophagus (Food pipe) =2 ; Stomach=3 ; Other pharynx= 4 ; Colo-rectum = 5; Larynx= 6; Liver =7 ; Lung = 8 ; Breast = 9; Cervix = 10; Ovary = 11; Prostate = 12 ; Gall bladder= 13; Others = 14; Unknown =15	Participant had symptoms=**1** At routine checkup or screening=**2** Not sure/Don't know=**3**	Stage0/in situ stage=**1**; Stage I= **2**; Stage II=**3**; Stage III=**4**; Stage IV=**5**; Don't know=**6**	
3.42What was the primary treatment? **[Yes=1; No=2]**	A. Surgery B. Hormone therapy C. Radiology (X-ray for treatment) D. Chemotherapy (cancer cell killing drugs) E. Palliative treatment (treatment to relieve pain) F. Non-allopathic (Ayurvedic/ Homeopathic/ traditional) G. Others H. Don't know		☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ If others is "1", then specify _____

PART- 3A-VA: PERCEIVED CANCER STIGMA	
Codes: Yes = 1; No = 2; Don't know = 3; Refused = 4	
3.43 If someone in your community had cancer, would they tell the neighbors?	☐
3.44 Do people in the community avoid talking or eating with a person having cancer?	☐
3.45 Are people in your community afraid that cancer can spread from person to person?	☐
3.46 Do people in the community think that cancer is a curse or result of past sins?	☐

PART-3 B: FRACTURE		
3.47 Have you ever had a broken bone or fracture?	Yes 1 No 2	☐ If "2" skip to "Q3.49"

3.48 If yes	Which bone/part of your body was fractured (Yes=1, No=2)	Age at most recent fracture for that bone*	Was this due to fall from standing height (example, falling in bathroom, fall while walking) (Yes=1, No=2)	If no, what was the cause?
Hip				
Wrist				
Spine/ Vertebra				
Others		Specify :-		

** If they had multiple fracture note the age of most recent fracture*

3.49 Has either of your parents or siblings had a fracture of the hip, wrist or spine?	Yes 1 No 2 Don't know 3	☐

PART- 3C: COMPLICATIONS (For all participants)		
3C-I: – FOOT ULCERS AND AMPUTATION		
3.50 Have you **EVER** had a non-healing ulcer/sore in the foot that took **more than 4 weeks** to heal?	Yes 1 No 2	☐
3.51 Do you walk around bare foot?	Yes 1 No 2	☐
3.52 Have you had an amputation?	Yes 1 No 2	☐ If "2" go to "PART 3C-*II*"
3.53 If '**YES'**, when was your most recent amputation?	☐☐☐☐ Year ☐☐ Month	

3.54 On which lower limb (right, left or both) was the amputation?	Right 1 Left 2 Both 3	☐
3.55 What was the level of amputation? **(If both legs had amputation, please note the highest level)**	Toe 1 Below ankle 2 Below knee 3 Above Knee 4	☐
3.56 What was the cause for the most recent amputation?	Injury 1 Diabetes 2 Infection 3 Diabetes and Injury 4 Diabetes and infection 5 Others 6	☐ **If Others (option 6), then specify** ----------
3.57 Do you have medical records or prescriptions from the ulcer diagnosis or amputation?	Yes 1 No 2 Don't Know 3	☐
3.58 Ask the participant whether they have medical records related to the events. If so, please take pictures of every page of the record.		
3C-II: **– EYES**		
3.59 Have you ever seen a doctor for difficulty with your eyesight other than your ordinary power glasses (spectacles)?	Yes 1 No 2	☐ **If " 2" go to "Section 4"**
3.60 If **"Yes",** did the doctor ever tell you that you have:	Cataract 1 Retinopathy 2 Both 3 Other 4	☐ **If Others (option 4), then specify** _____
3.61 If 2 or 3 for Q3.63 when was the retinopathy diagnosed?	☐☐ ☐☐ Year Month	
3.62 Have you undergone laser therapy (Photocoagulation) anytime?	Yes 1 No 2	☐ **If "2" skip to Q3.63**
3.63 If "Yes" for Q3.62, when?	☐☐ ☐☐ Year Month	
3.64 Do you have medical records or prescriptions?	Yes 1 No 2	☐
3.65 Ask the participant whether they have medical records related to the events. If so, please take pictures of every page of the record.		

Section:-4 DRUG INFORMATION	
4.1 In the past one week, have you taken any Allopathic drug (English / modern) for a disease? [Yes= 1; No =2]	☐ If "2" go to "Section 5"
4.2 If yes, provide details of all the medication that the participant is taking in the **PAST WEEK** of survey in the below columns	
Name of the drug (Write in CAPTIAL letters)	
a.	
b.	
c.	
d.	
e.	
f.	
g.	
h.	
i.	
j.	

Section-5: PATIENT HEALTH QUESTIONNAIRE -9 (PHQ-9)		
S.No	**Over the last 2 weeks, how often have you been bothered by any of the following problems (1-10)**	1. Not at All 2. Several Days 3. More than half the time 4. Nearly every day
A.	Have little interest or pleasure in doing things	☐
B.	Feeling down, depressed, or hope less	☐
C.	Trouble falling or staying asleep or sleeping too much	☐
D.	Feel tired or feel like having little energy	☐
E.	Poor appetite or overeat	☐
F.	Feeling bad about yourself – or that you are a failure or have let yourself or your family down	☐
G.	Trouble concentrating on things, such as reading the newspaper or watching television	☐
H.	Moving or speaking so slowly that other people could have noticed Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	☐
I.	Thoughts that you be better off dead, or of hurting yourself in some way	☐
J.	If you have checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people	☐ 1. Not difficult at all 2. Somewhat difficult 3. Very difficult 4. Extremely difficult

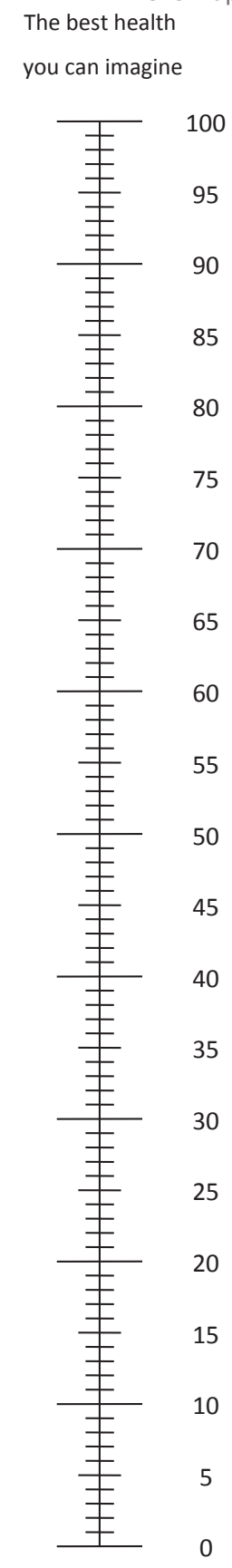
SECTION-6: QUALITY OF LIFE			
Under each heading, please mention the number that describes your health today			
A. Mobility	I have no problems in walking about	1	☐
	I have slight problems in walking about	2	
	I have moderate problems in walking about	3	
	I have severe problems in walking about	4	
	I am unable to walk about	5	
B. Self- Care	I have no problems in bathing or dressing myself	1	☐
	I have slight problems in bathing or dressing myself	2	
	I have moderate problems in bathing or dressing myself	3	
	I have severe problems in bathing or dressing myself	4	
	I am unable to bath or dress myself	5	
C. Usual Activities (e.g.. work, study housework family or leisure actvities)	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 peoblems doing my usual activities	4	
	I am unable to do my usual activites	5	
D. 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	
E. 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 7: FEMALE REPRODUCTIVE HISTORY (Only for Female)

PART- 7A: THIS SECTION TO BE FILLED ONLY FOR THE FEMALE PARTICIPANTS. FOR MALE PARTICIPANTS SKIP THIS SECTION AND THANK THE PARTICIPANT

7.1 Are you currently having menstrual cycles?	Yes 1 No 2	☐ **If "1" go to Q.7.4**
7.2 If '**No**' what is the reason?	Pregnancy 1 Lactation 2 Natural menopause 3 Surgical menopause 4 Others 5	☐ **If others (option 5), then specify** _____
7.3 If menopausal, since how long? **[*Ask if Q.7.2 is filled with option 3 or 4]***	☐☐ **YY** ☐☐ **MM**	
7.4 When was your last menstrual period (LMP)? **If the participant is able to recall skip to Q7.6 otherwise fill Q7.5a**	☐☐ **D D** ☐☐ **M M** ☐☐ **Y Y**	
7.5a If the participant cannot recall the date of her LMP	☐☐ **Y Y** ☐☐ **M M** ☐☐ **D D**	**Ago**
7.6 Are you currently using hormonal drugs or oral contraceptive pills? **[Yes= 1, No=2]**	☐	
7.7 Number of pregnancies so far? [**also include miscarriages/abortions]**	☐☐	**If 00, skip to Q7.12**
7.8 In the last pregnancy was the delivery :	Normal 1 Caesarian Section 2 Others 3 Not applicable 9	☐ **If others (option 3), then specify** _____
7.9 Were you diagnosed to have gestational diabetes in any of the pregnancies?	Yes 1 No 2 Don't know 3 Not applicable 9	☐
7.10 Were you diagnosed to have hypertension in any of the pregnancies?	Yes 1 No 2 Don't know 3 Not applicable 9	☐
7.11 What is the date of birth of your youngest biological child? **If the participant is able to recall skip to Q7.12 otherwise fill Q7.11a**	☐☐ **D D** ☐☐ **M M** ☐☐ **Y Y**	
7.11b What is the age of your youngest biological child?	☐☐ **YY** ☐☐ **MM**	

PART- 7B: CANCER SCREENING		
7.12 Have you ever had yours breasts examined by a physician, nurse or other health professional?	Yes 1 No 2 Don't know/ Not sure 3	☐ **If "2" or "3" skip to Q7.17**
7.13 Have you ever had the following exams done by a physician, nurse or other health professional? A. Breast examination B. Mammogram (A **mammogram** is an X-ray image of your breast used to screen for breast cancer)	**[Yes= 1; No= 2; Don't know/ Not sure= 3]** ☐ ☐ **If "2" or "3" skip to Q7.17**	
7.14 If yes for "Q7.13" when was the last time you had? <1 year ago 1 1-5 years ago 2 >5 years ago 3	Breast examination ☐	Mammogram ☐
7.15 Do you know why the breast exam was done? **[Yes=1; No=2]**		☐ **If "2" skip to Q7.17**
7.16 If yes, why was this examination done? **[Yes=1; No=2; Not sure/Don't know=3]**	A. General health check-up B. Doctor suggested to do the exam because of my age or family history of breast cancer C. I was having discomfort, pain or symptoms D. Others	☐ ☐ ☐ ☐ If others, please specify _____

7.17 Have you ever had the following exams for cervical cancer done by a physician, nurse or other health professional? A. **Pap smear** (Cervix is the mouth of the uterus. Cervical cancer can be detected even before there are symptoms by several tests. In pap-smear a doctor takes a sample of cells from the cervix) B. **Visual exam with acetic acid** (Cervix is the mouth of the uterus. Cervical cancer can be detected even before there are symptoms by several tests. In this test the doctor look at the mouth of the uterus, paint some vinegar on it, and see if there are any changes that look like cancer)	**[Yes= 1; No= 2; Don't know/ Not sure= 3]** ☐ ☐ **If "2" or "3" thank the participant and end the questionnaire**	
7.18 If yes for "Q7.17" when was the last time you had? <1 year ago 1 1-5 years ago 2 >5 years ago 3	Pap smear ☐	Visual exam with acetic acid ☐
7.19 Do you know why these exam done? **[Yes=1; No=2]**		☐ **If "2" thank the participant and end the questionnaire**
7.20 If yes for Q7.19 A. General health check-up B. Doctor suggested to do the exam because of my age or family history of breast cancer C. I was having discomfort, pain or symptoms D. Others	**[Yes=1; No=2]** ☐ ☐ ☐ ☐	If yes for others please specify _____ __

End time ☐☐ ☐☐

Hours : Minutes

FOR QUALITY CHECK

REVIEWER 1	REVIEWER 2	DATA ENTRY/SCANNING
NAME:_____	NAME:_____	NAME:_____
SIGNATURE:_____	SIGNATURE:_____	SIGNATURE:_____
DATE:_____/_____/_____	DATE:_____/_____/_____	DATE:_____/_____/_____