

Appendix -4

Andhra Pradesh Children And Parents Study
(APCAPS)
A Transgenerational extension of Hyderabad
Nutrition Trial
(Funded by the Wellcome Trust, U.K)

CLINIC QUESTIONNAIRE

Apply Subject details
Label here

Apply Study ID
Label here

Subject Type :

- 1 = Mother
- 2 = Father
- 3 = Sibling
- 4 = DXA

Participant info:

Name: _____

Date of birth: ____/____/____

Consent form	<input type="checkbox"/> [1=Yes; 2=No]	Lung function test	<input type="checkbox"/> [1=Yes; 2=No]
Blood	<input type="checkbox"/> [1=Yes; 2=No]	Vascular studies- NIN	<input type="checkbox"/> [1=Yes; 2=No]
Saliva	<input type="checkbox"/> [1=Yes; 2=No]	Spirometry -NIN	<input type="checkbox"/> [1=Yes; 2=No]
Questionnaire	<input type="checkbox"/> [1=Yes; 2=No]	DXA - NIN	<input type="checkbox"/> [1=Yes; 2=No]
Anthropometry	<input type="checkbox"/> [1=Yes; 2=No]	Doctor	<input type="checkbox"/> [1=Yes; 2=No]
TANITA	<input type="checkbox"/> [1=Yes; 2=No]	Reimbursement	<input type="checkbox"/> [1=Yes; 2=No]

Supported by

NATIONAL INSTITUTE OF NUTRITION, HYDERABAD, India
LONDON SCHOOL OF HYGIENE & TROPICAL MEDICINE, U.K.
&
UNIVERSITY OF BRISTOL, U.K.

PARTICIPANT INFORMATION SHEET

Andhra Pradesh Children And Parents Study (APCAPS)

Nutritional challenges, abdominal adiposity and type 2 diabetes in Indians: Parental and offspring cardio-metabolic risk - a Transgenerational Extension of the Hyderabad Nutrition Trial

Purpose of the study

Researchers at the National Institute of Nutrition in Hyderabad and at the London School of Hygiene and Tropical Medicine are interested in understanding the effects of poor nutrition and environmental circumstances during pregnancy and childhood, on the chances of diabetes and heart disease occurring in the offspring. You have been chosen for this study as you/your wife/your mother participated in an earlier study conducted by National Institute of Nutrition. At this time, some but not all the participants were provided with extra food with the help of the Anganwadi. We are trying to know from this research whether the chances of getting heart diseases have been reduced in the children of women who got extra food. These comparisons will help to predict future needs for health services in India which will benefit planning. The research will also help in understanding the health effects –both positive and negative–of nutritional supplementation which may lead to ideas for preventing bad outcomes. Finally, the study provides an opportunity for you to gain important information about your health status.

Questions and concerns

You are being invited to participate in this medical research study. Kindly read this information sheet attentively. If you are not clear about anything or there is any uncertainty, then you are free to ask any questions when you receive a visit from the study staff. Sign the consent letter only when you are able to understand the nature of this study fully along with your rights as a participant. You are free to discuss it with anybody, whose consultation is important to you.

Voluntary participation

It is entirely your decision to participate in the study. If you want to discontinue at any point of time, you are free to leave this study without stating any reason. Your medical care will not be affected by your decision.

What does it mean to participate?

Participation in this study involves answering some questions about your general and medical habits, having body measurements taken, your blood drawn (**15ml**), saliva (spits) sample taken and a short medical examination, which includes some measures of your heart and a breathing test. You will have a special type of X-ray taken to measure your body fat. Your answers are confidential and will be used only for the study.

You will be required to give a blood sample

You will be asked to fast overnight before the visit in which you give your blood samples. During the visit we will ask you to donate a small sample of your blood. Trained personnel will draw the blood. The supplies used for drawing blood will be safe and sterile and used only once and the supplies will be destroyed after use. The blood you give will be used for research purposes only. Any blood that is left over after the test will may be used for further test related to medical research including tests to find out whether any diseases run in the family.

Follow up in the future

The present research does not require the research team to see you again. However, important information can only be gained by linking your current health and life style to what happens to you in the future. Therefore, we would like to invite you to continue to participate in the future if you wish.

Benefits from the study

You will get a medical examination by an experienced team, including doctors. You will undergo the following tests: blood pressure, blood glucose for diabetes, haemoglobin, DXA scanning to measure fat levels, three tests on your heart and blood vessel function (arterial stiffness, pulse wave velocity and carotid intima media

thickness), respiratory function and saliva sampling for genetic studies. Counselling will be given to you based on the results of the medical examination and blood tests. You will be given your blood results.

By participating in this study you will help researchers gain a clearer understanding of how nutritional supplementation has an effect on diseases like obesity and diabetes. Your participation will also help them understand how lifestyle, physical activity and dietary habits affect your health.

Risks of participating in the study

We do not expect that you will incur any risks by participating in this study. Blood drawing may cause a small amount of discomfort, but it is only temporary.

Financial costs

You will not incur any costs as a result of your participation in this study. Your travel fare along with any other expenses incurred and loss of daily wages towards time spent for our study will be reimbursed. Refreshments will also be provided.

Confidentiality

If you decide to take part in the study, all details provided by you will be kept confidential and it will only be made available to investigators related to this study. Information will be stored in password protected computer in Hyderabad and in London. The results will be published in research magazines and reports. However, the names and details of the study subjects will not be disclosed and you will not be recognized from them.

Funding & Coordinating agency

The funds for this study are being provided by the Wellcome Trust, a major UK based research charity.

Ethical Review

The study proposal has been approved by the London School of Hygiene & Tropical Medicine and the National Institute of Nutrition.

Contact for further information

If you require any further information or need to clarify some issue, you can contact any of our study team members at National Institute of Nutrition, Hyderabad

Tel: Project Office: National Institute of Nutrition: 040 – 27197256

Project Officer: Ms. Santhi Bhogadi: 9885448240.

Field Manager: Mr. Aniket Kumar: 7207805927

What your signature means

Your signature on the next page means that you understand the information given to you about the study. If you sign the form it means that you agree to join the study. You will be provided a copy of this patient information sheet to keep with your records.

SECTION A: Consent Form

Andhra Pradesh Children And Parents Study (APCAPS)
Nutritional challenges, abdominal adiposity and type 2 diabetes in Indians: Parental and offspring
cardio-metabolic risk - a Transgenerational Extension of the Hyderabad Nutrition Trial

Participant: Shri/Smt/Kum (First & Last Name) _____

Address (Lane, Town, State, Pincode) _____

I, _____ exercising my free power of choice, hereby give my consent to be included as a subject in the clinical study - **Andhra Pradesh Children And Parents Study (APCAPS)** “Nutritional challenges, abdominal adiposity and type 2 diabetes in Indians”- Parental and offspring cardio-metabolic risk: - a Transgenerational Extension of the Hyderabad Nutrition Trial.

(For the examination today we will ask you to undertake the following: interview, measurement of body size, DXA scan and a visit with the doctor. We will also ask you to give up to two blood samples. The examination will last until the afternoon.)

- I am free to participate or not to participate in this study.
- The purpose of this study was explained to me in my own language.
- I have been given the opportunity to ask questions and reply was given for all the questions to my satisfaction.
- I have been informed by the investigators about the process including the nature, objective and known likely inconveniences related to this study and I have understood them.
- My medical data are strictly confidential and I only authorise the persons, involved in the research, identified by the sponsor or health authorities to consult about the same.
- By signing this form, I give my free and informed consent to take part in this study as outlined in the information sheet and this consent form. Specifically, I agree to being interviewed, examined and having **(15 ml)** blood drawn. I agree to my information, including results of blood tests, to be used in research.
- I give permission for any blood that is left over after the tests to be stored and used for further laboratory tests for medical research
- I understand that for all practical purposes I may not gain anything by participating in the study though in the long run it may be beneficial to the community.
- I understand that I can withdraw from the study at any point without giving any reasons and withdrawing from the study will not affect me in any way.
- I understand that I will receive a very small radiation dose from the DXA scan, so I shouldn't have this scan if I am pregnant.
- I have been given a copy of the information sheet and consent form to keep. By signing this form I have not given up my legal rights.

Name of the Participant _____ Signature of the Participant _____

Date _____

Name of the Investigator _____ Signature of the Investigator _____

Date _____

SECTION B: Consent form for genetic component of the study

Andhra Pradesh Children And Parents Study (APCAPS)

Nutritional challenges, abdominal adiposity and type 2 diabetes in Indians: Parental and offspring cardio-metabolic risk - a Transgenerational Extension of the Hyderabad Nutrition Trial

Participant: Shri/Smt/Kum (First & Last Name) _____

Address (Lane, Town, State, Pin Code) _____

I, _____ exercising my free power of choice, hereby give my consent to be included as a subject in the clinical study - **Andhra Pradesh Children And Parents Study (APCAPS)** “Nutritional challenges, abdominal adiposity and type 2 diabetes in Indians”- Parental and offspring cardio-metabolic risk: - a Transgenerational Extension of the Hyderabad Nutrition Trial.

(For the examination today we will ask you to undertake the following: interview, measurement of body size, DXA scan and a visit with the doctor. We will also ask you to give up to two blood samples. The examination will last until the afternoon.)

- I am free to participate or not to participate in this study.
- The purpose of this study was explained to me in my own language.
- I have been given the opportunity to ask questions and reply was given for all the questions to my satisfaction.
- I have been informed by the investigators about the process including the nature, objective and known likely inconveniences related to this study and I have understood them.
- My medical data are strictly confidential and I only authorise the persons, involved in the research, identified by the sponsor or health authorities to consult about the same.
- By signing this form, I give my free and informed consent to take part in this study as outlined in the information sheet and this consent form. Specifically, I agree to being interviewed, examined, having saliva samples taken and blood drawn (**15ml**) for necessary tests. I agree to my information, including results of blood tests, to be used in research.
- I understand that the saliva sample and blood sample may be used for genetic research aimed at understanding genetic and epigenetic influences on diseases.
- I understand that for all practical purposes I may not gain anything by participating in the study though in the long run it may be beneficial to the community.
- I understand that I can withdraw from the study at any point without giving any reasons and withdrawing from the study will not affect me in any way.
- I have been given a copy of the information sheet and consent form to keep. By signing this form I have not given up my legal rights.

Name of the Participant _____ Signature of the Participant _____

Date _____

Name of the Investigator _____ Signature of the Investigator _____

Date _____

NATIONAL INSTITUTE OF NUTRITION (ICMR)

JAMAI OSMANIA (P.O.), HYDERABAD - 500 007

భారతీయులలో పోషకాహార సమస్యలు, ఉదర భాగమునందు క్రొవ్వు చేరుట మరియు టైపు2 మధుమేహము - తల్లిదండ్రులు మరియు వారి పిల్లలకు హృదయతత్వ పరిణామములకు అపాయము : తరతరాల మార్పులు, హైదరాబాదు పోషకాహార శోధనకు పొడిగింపు.

(Study title : "Nutritional Challenges, Abdominal Adiposity and type 2 diabetes in Indians - parental and offspring cardio - metabolic risk : a trans - generational extension of Hyderabad nutrition trial)

పాల్గొను వారికి విషయ సూచిక

అధ్యయనం యొక్క ఆవశ్యకత :

తల్లి గర్భములో మరియు చిన్నతనములో పోషకాహార లోపము మరియు పరిసరాల యొక్క ప్రభావము వలన పిల్లల్లో మధుమేహము మరియు గుండె జబ్బులు వచ్చుటకు గల అవకాశములపై జాతీయ పోషకాహార సంస్థ, హైదరాబాదు మరియు లండన్ స్కూల్ ఆఫ్ హైజీన్ మరియు ట్రాపిక్ అండ్ మెడిసిన్ లో పనిచేయు పరిశోధకులు అధ్యయనం చేయదలచినారు. మీరు/ మీ భార్య / మీ అమ్మ గతంలో జాతీయ పోషకాహార సంస్థ నిర్వహించి అధ్యయనములో పాల్గొనినారు కావున మిమ్మల్ని ఈ అధ్యయనములో పాల్గొనుటకు ఎంచుకొనినారు. ఈ సమయములో కొంతమంది చూలంతలకు అంగన్ వాడీ ద్వారా అధిక ఆహారం ఇవ్వబడినది. ఈ అధ్యయనం ద్వారా అధిక ఆహారము తీసుకొనిన వారికి పుట్టిన పిల్లలకు గుండెకు సంబంధించిన జబ్బులు వచ్చుటకు అవకాశము తక్కువగా ఉండునేమో అని తెలుసుకొనదలచినారు. ఈ అనుసంధానము వలన భవిష్యత్ లో భారతదేశములో ఆరోగ్యపరమైన సేవలు చేయుటకు దోహదపడును. ఈ పరిశోధన వలన ఆరోగ్యముపై ప్రభావమును అర్థం చేసుకొనుటకు అధిక పోషకాహారము వలన కలుగు మంచి/ చెడు ప్రభావములు తెలుసుకొని, చెడు ప్రభావములను నివారించడానికి దోహదపడును. చివరిగా ఈ అధ్యయనములో మీ ప్రస్తుత ఆరోగ్య పరిస్థితి తెలుసుకొనుటకు అవకాశము లభించును.

ప్రశ్నలు మరియు నిమిత్తములు :

మిమ్మల్ని వైద్య సంబంధ పరిశోధన చేయు అధ్యయనములో పాల్గొనుటకు ఆహ్వానించుచున్నాము. దయచేసి ఈ విషయ సూచికను జాగ్రత్తగా చదువగలరు. మీకు ఈ ఏ విషయమైన అర్థం కాని ఎడల లేదా ఏ విషయముపైనైన అనుమానం ఉన్నచో, అధ్యయనములో పనిచేయు ఉద్యోగస్తులను అడిగి తెలుసుకొనుటకు మీరు పూర్తి స్వేచ్ఛ కలిగి ఉన్నారు. ఈ అధ్యయనము యొక్క స్వభావముతో పాటు మీరు పాల్గొనుటకు గల అధికారము పూర్తిగా అర్థమైన తరువాతనే అంగీకార పత్రముపై సంతకము చేయగలరు. ఈ విషయములు మీరు మీకు ముఖ్యమైన వారితో చర్చించుటకు పూర్తి స్వేచ్ఛను కలిగి ఉన్నారు.

పాల్గొనుటకు స్వేచ్ఛ :

ఈ అధ్యయనములో పాల్గొనుటకు పూర్తిగా మీ నిర్ణయం. ఏ సమయములోనైనా మీరు ఈ అధ్యయనము నుండి విరమించుకొనదలచినచో, ఎవ్వరికి ఏ కారణము తెలుపకుండానే ఈ అధ్యయనము నుండి తప్పుకొనవచ్చును. ఈ నిర్ణయము వలన మీ వైద్య సంరక్షణ మరియు ఉద్యోగముపై ఎటువంటి ప్రభావము ఉండదు.

పాల్గొనుట అనగానేమి?

ఈ అధ్యయనములో పాల్గొనుట అనగా మీరు మీ వైద్య సంబంధ అలవాట్లకు సంబంధించిన ప్రశ్నలకు సమాధానములు తెలుపుట. మీ శరీర కొలతలను తీసుకొనుట. 15 మి.లీ. రక్తము మరియు ఉమ్మి నమూనా తీసుకొనుట మరియు గుండె, గాలి తీసుకొను ఎక్స్ రేను తీయించుకొనడం. మీ సమాధానములు గుప్తముగా ఉంచబడును మరియు ఈ అధ్యయనమునకు మాత్రమే ఉపయోగించుకొనబడును.

మీరు రక్త నమూనా ఇవ్వవలసి ఉండును :

రక్త నమూనా కొరకు మిమ్మల్ని రాత్రి నుండి ఏమి ఆహారము తీసుకొనకుండా ఉండమని అడిగెదము. మీరు వచ్చిన తరువాత ఒక చిన్న రక్త నమూనా తీసుకొనదము. ప్రజ్ఞావంతులైన నిపుణులచే రక్తము తీయించబడును. మీరు ఇచ్చిన రక్తము పరిశోధనకు మాత్రమే ఉపయోగించబడును.

భవిష్యత్ విచారణ :

ప్రస్తుత పరిశోధనకు, పరిశోధకులు ఎవ్వరు మిమ్మల్ని మరల చూడనవసరము లేదు. కాని, మీ ప్రస్తుత ఆరోగ్యము మరియు జీవన విధానము, భవిష్యత్ కాలములో మీకు ఎలా ఉండును అన్న విషయములను అనుసంధానము చేయుటచే ముఖ్య సమాచారము లభించును. అందువలన, మిమ్మల్ని మరల భవిష్యత్లో కూడా పాల్గొనుటకు ఆహ్వానించుచున్నాము.

అధ్యయనము వలన లాభములు :

మీకు అనుభవజ్ఞులైన వైద్యులచే వైద్య పరీక్షలు నిర్వహించబడును. మీకు బి.పి., మధుమేహము కొరకు షగరు పరీక్ష, రక్త శాతము, కొవ్వును కొలువు డెక్సా స్కానింగ్, గుండె మరియు రక్త నాళముల పనితీరును కనుగొనుటకు (ఆర్టిర్యల్ స్ప్రెస్సెస్, ఫ్లోవేవ్ వెలాసిటీ, కరోటిడ్ ఇంటిమా మీడియా టిక్నెస్) మరియు ఉచ్ఛ్వాస, నిచ్ఛ్వాస క్రియల పరీక్షలు చేయబడును. మీ వైద్య మరియు రక్త పరీక్ష యొక్క ఫలితములను ఇవ్వబడును. మరియు వాటి ఆధారముగా తగిన సలహాలను ఇవ్వబడును. ఈ అధ్యయనములో పాల్గొనుట వలన పరిశోధకులకు అధిక పౌష్టికాహారము ఇవ్వడం వలన ఊబకాయము, మధుమేహము వంటి రోగములకు సంబంధము గురించి తెలుసుకొనుటకు అవకాశము కలుగును. మీరు ఈ అధ్యయనములో పాల్గొనుట వలన జీవన విధానము, స్వాభావిక విధానము మరియు ఆహార లక్షణములు మీ ఆరోగ్యముపై ప్రభావమును అర్థం చేసుకొనుటకు దోహదపడును.

అధ్యయనములో పాల్గొనుట వలన కలుగు అపాయములు :

ఈ అధ్యయనములో పాల్గొనుట వలన మీకు ఎటువంటి అసౌకర్యము కలుగునని భావించుట లేదు. రక్తము తీయునప్పుడు కొంచెము అసౌకర్యముగా అనిపించవచ్చును. కాని ఇది తాత్కాలికము.

ఆర్థిక వరమైన ఖర్చులు :

ఈ అధ్యయనములో పాల్గొనుట వలన మీకు ఎటువంటి ఆర్థికవరమైన ఇబ్బందులు కలుగవు. మీ ప్రయాణ ఛార్జీలు మరియు మీ పనిని మానుకొని ఆ సమయమును ఈ అధ్యయనము కొరకు వెచ్చించినందుకుగాను మీకు తగిన పరిహారము ఇవ్వబడును. ఆహారము కూడా ఇవ్వబడును.

గోప్యము :

ఈ అధ్యయనములో మీరు పాల్గొనదలచిన, మీకు సంబంధించిన వివరములన్నీ గోప్యముగా ఉంచబడును. మరియు ఆ వివరములన్నీ ఈ అధ్యయనములో పనిచేయు వారికి మాత్రమే తెలియును. మీ వివరములన్నీ హైదరాబాదు మరియు లండన్లో పాస్ వర్డ్ ఉన్న కంప్యూటర్లో భద్రపరచబడును. ఈ ఫలితములు పరిశోధనా పత్రికలలో మరియు సమాచార పత్రములలో ముద్రించబడును. కాని, ఈ అధ్యయనములో పాల్గొనువారి పేర్లు మరియు ఇతర వివరములేవి తెలియరావు, మిమ్మల్ని ఈ వివరముల వలన గుర్తించుట జరుగదు.

ఆర్థిక సహకారము మరియు తుల్య సంస్థ :

ఈ అధ్యయనమునకు ఆర్థిక సహకారము వెల్ కంట్రస్ట్, యు.కె. అను పరిశోధన దాతృత్వ సంస్థ అందించుచున్నది.

వైతికవరమైన నమీక్ష :

ఈ అధ్యయన యోచనను లండన్ స్కూల్ ఆఫ్ హైజీన్ మరియు ట్రాఫికల్ మెడిసిన్ మరియు జాతీయ పోషకాహార సంస్థ వారిచే ఆమోదించబడినది.

సమాచారము తెలుసుకొనుట :

ఇతరత్ర ఏ విషయమైన తెలుసుకొనదలచిన లేదా ఏ విషయమైన విశదపరచుటకు మీరు ఈ అధ్యయనములకు సంబంధించిన ఉద్యోగస్థులను జాతీయ పోషకాహార సంస్థ, హైదరాబాద్లో సంప్రదించవచ్చును.

ఫాన్ నెంబర్లు :

- ప్రాజెక్ట్ అఫీసు : జాతీయ పోషకాహార సంస్థ : 040-27197256
- ప్రాజెక్ట్ అఫీసర్ : శాంతి భోగాది : 9885448240
- ఫీల్డ్ మేనేజర్ : అనికేత్ కుమార్ : 7207805927

మీ సంతకము అనగా :

తదుపరి పత్రముపై మీ సంతకము అనగా మీరు ఈ సమాచార పత్రమును అర్థం చేసుకొనివారు అని భావించెదము. ఈ పత్రముపై సంతకము అనగా ఈ అధ్యయనములో పాల్గొనుటకు అంగీకరించిన భావించెదము. మీకు అధ్యయనము యొక్క సమాచార పత్రము ఇవ్వబడును.

NATIONAL INSTITUTE OF NUTRITION (ICMR)

JAMAI OSMANIA (P.O.), HYDERABAD - 500 007

భారతీయులలో పోషకాహార సమస్యలు, ఉదర భాగమునందు క్రొవ్వు చేరుట మరియు టైపు 2 మధుమేహము - తల్లిదండ్రులు మరియు వారి పిల్లలకు హృదయతత్వ పరిణామములకు అపాయము : తరతరాల మార్పులు, హైదరాబాదు పోషకాహార శోధనకు పొడిగింపు.

(Study title : "Nutritional Challenges, Abdominal Adiposity and type 2 diabetes in Indians - parental and offspring cardio - metabolic risk : a trans - generational extension of Hyderabad nutrition trial)

'ఎ' భాగము అంగీకార పత్రము

పాల్గొను వారు :

శ్రీ / శ్రీమతి / కుమారి (మొదటి అండ్ చివరి పేరు)

చిరునామ (వీధి, ఊరు పేరు, రాష్ట్రము, పిన్ నెంబరు)

నేను ("భారతీయులలో పోషకాహార సమస్యలు, ఉదర భాగమునందు క్రొవ్వు మరియు టైపు 2 మధుమేహం") వ్యాధులపై జరుపుచున్న అధ్యయనములో పాల్గొనుటకు నా సమ్మతిని, స్వేచ్ఛను ఉపయోగించుకుంటున్నాను. (ఈ రోజు జరుగుచున్న ఈ పరీక్షలో మిమ్మల్ని మేము ఇంటర్వ్యూవ్ ఇవ్వమని, శరీర కొలతలు, డాక్టర్ల సలహా మరియు డాక్టరు చేత పరీక్ష చేయించుకొనమని కోరడము. రెండు రకము మరియు ఉమ్మి నమూనాలు ఇవ్వమని అడిగెదము. ఈ పరీక్షలన్నీ మధ్యాహ్నం వరకు జరుగును.)

- * ఈ అధ్యయనములో పాల్గొనుట పాల్గొనకపోవుటను నిర్ణయించుకొనుటకు నాకు స్వేచ్ఛ కలదు.
- * ఈ అధ్యయనము యొక్క ఆవశ్యకతను నా మాతృభాషలో వివరించినారు.
- * ప్రశ్నలు వేయడానికి నాకు అవకాశమిచ్చి, అన్ని ప్రశ్నలకు సంతృప్తికరమైన సమాధానములు ఇచ్చినారు.
- * అధ్యయనము యొక్క విధానము, స్వభావము, ఉద్దేశము మరియు తెలిసిన, కలుగు అసౌకర్యముల గురించి ఈ అధ్యయనములో పనిచేయువారు తెలియజేసినారు. నేను అర్థం చేసుకున్నాను.
- * నా వైద్య సంబంధము ఐన సమాచారమంతయు అతి రహస్యముగా మరియు పరిశోధనకు సహకరించు వారిచే గుర్తింపు పొందిన వారు లేక ఆరోగ్య సంబంధిత అధికారులకు మాత్రమే, తెలుసుకొనుటకు అవకాశము ఇస్తాను.
- * ఈ పత్రముపై సంతకం చేయడం ద్వారా, సమాచార మరియు సమ్మతి పత్రములో రూపొందించిన విషయములపై మరియు తెలియపరచిన వాటిపై, నన్ను ప్రశ్నించడానికి, పరీక్షించటానికి మరియు ఉమ్మి, రక్త నమూనా (15మి.లీ) తీసుకొనుటకు నా సమ్మతిని తెలియజేయుచున్నాను. నా సమాచారము, రక్త పరీక్ష ఫలితాలను పరిశోధనకు ఉపయోగించవచ్చును.
- * పరీక్ష తరువాత మిగిలిన రక్తమును, నిల్వచేయుటకు మరియు వైద్య పరిశోధనలకై జరిపే పరీక్షలకు ఉపయోగించుకొనుటకు నేను అనుమతిస్తాను.
- * ఈ అధ్యయనము ధీర్ఘకాలంలో సమాజానికి ఉపయోగపడినప్పటికిని, నాకు మాత్రము ఎలాంటి లాభం కలుగదని తెలుసును.
- * ఈ అధ్యయనము నుండి ఏ కారణము తెలుపకుండా ఎప్పుడైనా విరమించుకొనవచ్చునని నేను అర్థం చేసుకున్నాను, మరియు విరమించుకోవడం వల్ల నాపై ఎటువంటి ప్రభావము ఉండదు.
- * డెక్లారేషన్ గా నుండి చిన్నపాటి కిరణాలను గ్రహించవలసి ఉండును కావున, నేను గర్భవతిని అయినచో ఈ స్కానింగ్ చేయించుకోకూడదు అని అర్థం చేసుకొనినాను.
- * విషయ సూచిన మరియు అంగీకార పత్రము ఉంచుకొనుటకు నాకు ఇవ్వబడినది. ఈ పత్రముపై సంతకము చేయడం వలన నా న్యాయపరమైన హక్కులను కోల్పోను.

పాల్గొను వారి పేరు

పాల్గొను వారి సంతకం తేది :

ఇన్వెస్టిగేటర్ పేరు :

ఇన్వెస్టిగేటర్ సంతకము :తేది :

NATIONAL INSTITUTE OF NUTRITION (ICMR)

JAMAI OSMANIA (P.O.), HYDERABAD - 500 007

భారతీయులలో పోషకాహార సమస్యలు, ఉదర భాగమునందు క్రొవ్వు చేరుట మరియు టైపు 2 మధుమేహము - తల్లిదండ్రులు మరియు వారి పిల్లలకు హృదయతత్వ పరిణామములకు అపాయిము : తరతరాల మార్పులు, హైదరాబాదు పోషకాహార శోధనకు పొడిగింపు.

(Study title : "Nutritional Challenges, Abdominal Adiposity and type 2 diabetes in Indians - parental and offspring cardio - metabolic risk : a trans - generational extension of Hyderabad nutrition trial)

'బి' భాగము : జన్యుసంబంధిత విభాగము కొరకు అంగీకార పత్రము

పాల్గొను వారు :

శ్రీ / శ్రీమతి / కుమారి (మొదటి అండ్ చివరి పేరు)

చిరునామ (వీధి, ఊరు పేరు, రాష్ట్రము, పిన్ నెంబరు)

నేను ("భారతీయులలో పోషకాహార సమస్యలు, ఉదర భాగమునందు క్రొవ్వు మరియు టైపు 2 మధుమేహం") వ్యాధులపై జరుపుచున్న అధ్యయనములో పాల్గొనుటకు నా సమ్మతిని, స్వేచ్ఛను ఉపయోగించుకుంటున్నాను. (ఈ రోజు జరుగుచున్న ఈ పరీక్షలో మిమ్మల్ని మేము ఇంటర్వ్యూవ్ ఇవ్వమని, శరీర కొలతలు, డాక్టర్స్ మరియు డాక్టర్ల చేత పరీక్ష చేయించుకొనమని కొరడము. రెండు రక్తము మరియు ఉమ్మి నమూనాలు ఇవ్వమని అడిగెదము. ఈ పరీక్షలన్నీ మధ్యాహ్నం వరకు జరుగును.)

- * ఈ అధ్యయనములో పాల్గొనుట పాల్గొనకపోవుటను నిర్ణయించుకొనుటకు నాకు స్వేచ్ఛ కలదు.
- * ఈ అధ్యయనము యొక్క ఆవశ్యకతను నా మాతృభాషలో వివరించినారు.
- * ప్రశ్నలు వేయడానికి నాకు అవకాశమిచ్చి, అన్ని ప్రశ్నలకు సంతృప్తికరమైన సమాధానములు ఇచ్చినారు.
- * అధ్యయనము యొక్క విధానము, స్వభావము, ఉద్దేశము మరియు తెలిసిన, కలుగు అసౌకర్యముల గురించి ఈ అధ్యయనములో పనిచేయువారు తెలియజేసినారు. నేను అర్థం చేసుకున్నాను.
- * నా వైద్య సంబంధము ఐన సమాచారమంతయు అతి రహస్యముగా మరియు పరిశోధనకు సహకరించు వారిచే గుర్తింపు పొందిన వారు లేక ఆరోగ్య సంబంధిత అధికారులకు మాత్రమే, తెలుసుకొనుటకు అవకాశము ఇస్తాను.
- * ఈ పత్రముపై సంతకం చేయడం ద్వారా, సమాచార మరియు సమ్మతి పత్రములో రూపొందించిన విషయములపై మరియు తెలియపరచిన వాటిపై, నన్ను ప్రశ్నించడానికి, పరీక్షించడానికి మరియు ఉమ్మి, రక్త నమూనా 15 మి.లీ తీసుకొనుటకు నా సమ్మతిని తెలియజేయుచున్నాను. నా సమాచారము, రక్త పరీక్ష ఫలితాలను పరిశోధనకు ఉపయోగించవచ్చును.
- * నా ఉమ్మి మరియు రక్త నమూనా, రోగములపై జన్యు మరియు వంశపారంపర్యగా వచ్చుచున్న జన్యు సంబంధిత మార్పుల యొక్క ప్రభావమును అధ్యయనము చేయు జన్యు పరిశోధనకు ఉపయోగించెదరని అర్థం చేసుకొనినాను.
- * ఈ అధ్యయనము ధీర్ఘకాలంలో సమాజానికి ఉపయోగపడినప్పటికీ, నాకు మాత్రము ఎలాంటి లాభం కలుగదని తెలుసును.
- * ఈ అధ్యయనము నుండి ఏ కారణము తెలుపకుండా ఎప్పుడైనా విరమించుకొనవచ్చునని నేను అర్థం చేసుకున్నాను, మరియు విరమించుకోవడం వల్ల నాపై ఎటువంటి ప్రభావము ఉండదు.
- * డెక్లారేషన్ నుండి చిన్నపాటి కిరణాలను గ్రహించవలసి ఉండును కావున, నేను గర్భవతిని అయినచో ఈ స్కానింగ్ చేయించుకోకూడదు అని అర్థం చేసుకొనినాను.
- * విషయ సూచిన మరియు అంగీకార పత్రము ఉంచుకొనుటకు నాకు ఇవ్వబడినది. ఈ పత్రముపై సంతకము చేయడం వలన నా న్యాయపరమైన హక్కులను కోల్పోను.

పాల్గొను వారి పేరు

పాల్గొను వారి సంతకం తేది :

ఇన్వెస్టిగేటర్ పేరు :

ఇన్వెస్టిగేటర్ సంతకము : తేది :

SECTION A: Reimbursement

Summary sheet (to be completed at time of reimbursement)			
	Reimbursement		
1.1	Reimbursement given	<input type="checkbox"/> [1=Yes; 2=No]	
1.2	Identity proof taken	<input type="checkbox"/> [1=Yes; 2=No]	
	Subject recall		
1.3	Subject needs to be recalled	<input type="checkbox"/> [1=Yes; 2=No]	
1.4	Recall for repeatability study	<input type="checkbox"/> [1=Yes; 2=No]	
1.5	Recall for validation study	<input type="checkbox"/> [1=Yes; 2=No]	
1.6	Recall for incomplete study	<input type="checkbox"/> [1=Yes; 2=No]	
1.7	If yes, is the subject willing to return?	<input type="checkbox"/> [1=Yes; 2=No; 3=Undecided]	
1.8	If undecided, date status will be reviewed:	__ __ / __ __ / __ __ [DD/MM/YY]	
1.9	If recalled, clinic visit details		
	(a) Date of clinic visit [DD/MM/YY]	(b) Travel [1=Self; 2=Team]	(c) Outcome [1=Yes; 2=No]
	__ __ / __ __ / __ __		
	__ __ / __ __ / __ __		
	__ __ / __ __ / __ __		
1.10	Summary sheet notes		
Accelerometer			
1.11	Accelerometer number	<input type="text"/> <input type="text"/>	
1.12	Date of initiation	__ __ / __ __ / __ __ [DD/MM/YY]	
1.13	Time of initiation	<input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> [Hours: minutes; 24-hour clock]	
1.14	Date of termination	__ __ / __ __ / __ __ [DD/MM/YY]	
1.15	Time of termination	<input type="text"/> <input type="text"/> Hours <input type="text"/> <input type="text"/> Minutes	
1.16	Comments	<hr/> <hr/>	

SECTION B: Blood Sampling

Blood sampling	
2.1	Any illness within the last week? <input type="checkbox"/> [1=Yes; 2=No]
2.2	If yes, specify what illness: Cold <input type="checkbox"/> Cough <input type="checkbox"/> Headache <input type="checkbox"/> Fever <input type="checkbox"/> Bodyaches <input type="checkbox"/> Pain Abdomen <input type="checkbox"/> Diarrhoea <input type="checkbox"/> Vomiting <input type="checkbox"/> Others <input type="checkbox"/> Specify _____
2.3	(a) Was this illness or some other reason responsible for reduction in food intake over the last week? <input type="checkbox"/> 1=No reduction <input type="checkbox"/> 2=Minor reduction <input type="checkbox"/> 3=Major reduction
	(b) Do you have diabetes? <input type="checkbox"/> [1=Yes; 2=No]
	(c) Are you pregnant? <input type="checkbox"/> [1=Yes; 2=No]
2.4	Day of last meal <input type="checkbox"/> [1=Today; 2=Yesterday]
2.5	Time of last meal <input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> [Hours: minutes; 24-hour clock]
2.6	Time blood sample taken: <input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> [Hours: minutes; 24-hour clock]
2.7	Saliva sample taken <input type="checkbox"/> [1=Yes; 2=No]
2.8	
2.9	
	Success in blood sampling
	(a) Volume
	(b) Clot formation
2.10	Red capped tube <input type="checkbox"/> [1=No; 2=Partial; 3=Complete]
2.11	Purple capped tube 1 <input type="checkbox"/> [1=No; 2=Partial; 3=Complete]
2.12	Grey capped tube <input type="checkbox"/> [1=No; 2=Partial; 3=Complete]
2.13	Purple capped tube 2 <input type="checkbox"/> [1=No; 2=Partial; 3=Complete]
2.15	(a) Any other comments on blood sample <input type="checkbox"/> [1=Yes; 2=No]
	(b) If yes, specify _____

SECTION C: Clinical Questionnaire

Interview details	
3.1	Date of quest. completion ____ / ____ / ____ [DD/MM/YY]
3.2a.	Time of quest. Starting <input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> [Hours: minutes; 24-hour clock]
3.3	Interviewer code <input type="text"/> <input type="text"/>
3.4	Interviewer initials <input type="text"/> <input type="text"/> <input type="text"/>
First of all I would like to collect some details about you and where you live at present	
Contact details	
4.1	Family name _____ [Surname]
4.2	First name/middle name _____ [Forename/other name]
4.3	Current house address (if any) [House No./ Street / Locality] _____ _____
4.4	Place name _____ [Name of Village/Town/City]
4.5	PIN Code <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
4.6	Sub-district _____ [Tehsil/Taluk/Mandal/Municipality]
4.7	District _____
4.8	Nearest railway station _____
4.9	Nearest big town _____ [In case of village only]
4.10	State _____ [Name of country if abroad]
4.11	Type of place <input type="checkbox"/> [1=Village; 2=Town; 3=Small city; 4=Large city]
4.12	Census code <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
4.13	Home telephone number (landline) (<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> [Area code] [Phone number]
4.14	Mobile number <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Now I would like to collect some personal information about you	

Personal details	
5.1	Age last birthday <input type="text"/> <input type="text"/> [In completed years]
5.2	Day of birth <input type="text"/> <input type="text"/> [DD]
5.3	Month of birth <input type="text"/> <input type="text"/> [MM]
5.3a.	Season of birth Summer <input type="checkbox"/> Rainy season <input type="checkbox"/> Winter <input type="checkbox"/>
5.4	Year of birth <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> [YYYY]
5.4a	Birth weight <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> gms Records-1; Recall-2
5.4b	If you do not know birth weight, try to recall if - Thin baby <input type="checkbox"/> Normal wt <input type="checkbox"/> Heavy baby <input type="checkbox"/>
5.5	Sex <input type="checkbox"/> [1=Male; 2=Female]
5.6 a	Sibling History
	(a) How many brothers (alive) do you have? <input type="text"/> <input type="text"/> [Enter 00 if None]
	(b) How many sisters (alive) do you have? <input type="text"/> <input type="text"/> [Enter 00 if None]
	(c) What was your birth order in your family? <input type="text"/> <input type="text"/>
	(d) Do you have a twin brother or sister? <input type="checkbox"/> [1=Yes; 2=No]
5.6 b	Ethnicity and religion
	What is your place of Origin ? _____
	(b) Which category do you belong to? <input type="checkbox"/> 1 – General , 2 – SC , 3 – ST , 4 – OBC , 5 - Others
	(c) What religion do you belong to ? <input type="checkbox"/> 1 – Muslim , 2 – Hindu , 3 – Christian , 4 – Others
	(d) In case of Hindu General Category, what caste to you belong to ? <input type="checkbox"/> 1- Brahmin, 2 - Kshatriya, 3-Vaish, 4 - Others
	(e) In case you are a Muslim which category do you belong to? <input type="checkbox"/> 1- Shia 2 - Sunni 3 - Other
	(f) If belonging to a Tribe, which one do you belong to? _____

5.6 c	<p>Consanguinity</p> <p>(a) If married, is your spouse a close relative before marriage? <input type="checkbox"/> 1-Yes 2- No</p> <p>(b) If yes, what is the relation? <input type="checkbox"/> 1-Sibling, 2- First cousin (paternal/maternal), 3. Second cousin (paternal/maternal) 4. Uncle (maternal/paternal) 5. Niece (paternal/Maternal) 6. Other</p>																					
5.7	Current marital status <input type="checkbox"/>	1=Never married 2=Married 3=Widow/widower 4=Separated/divorced																				
5.8	If ever married:																					
	(a) How old were you when you first started living with your spouse after your marriage?	<input type="checkbox"/> <input type="checkbox"/> [Age in completed years]																				
	(b) Does your spouse normally live with you now?	<input type="checkbox"/> [1=Yes; 2=No]																				
5.9	How many (live) sons do you have?	<input type="checkbox"/> <input type="checkbox"/> [Enter 00 if None]																				
5.10	How many (live) daughters do you have?	<input type="checkbox"/> <input type="checkbox"/> [Enter 00 if None]																				
5.10a	What was the index child/children's birth order (BO)?	<input type="checkbox"/> , <input type="checkbox"/> , <input type="checkbox"/> , <input type="checkbox"/>																				
5.10b	Please recall whether the child/children (all) received nutritional supplementation from the Anganwadi Yes=1 and No=2 i. If yes, at what age.	<table border="0"> <thead> <tr> <th></th> <th>BO</th> <th>b. Supplemented</th> <th>i. Age</th> </tr> </thead> <tbody> <tr> <td>1.</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>2.</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>3.</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>4.</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> </tr> </tbody> </table>		BO	b. Supplemented	i. Age	1.	<input type="checkbox"/>	<input type="checkbox"/>	_____	2.	<input type="checkbox"/>	<input type="checkbox"/>	_____	3.	<input type="checkbox"/>	<input type="checkbox"/>	_____	4.	<input type="checkbox"/>	<input type="checkbox"/>	_____
	BO	b. Supplemented	i. Age																			
1.	<input type="checkbox"/>	<input type="checkbox"/>	_____																			
2.	<input type="checkbox"/>	<input type="checkbox"/>	_____																			
3.	<input type="checkbox"/>	<input type="checkbox"/>	_____																			
4.	<input type="checkbox"/>	<input type="checkbox"/>	_____																			
5.10c	What was the index child's gender?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> [1=Male; 2=Female]																				
5.10d	Was the child breast-fed?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Yes =1 and No=2																				
5.10e	What was the duration of EXCLUSIVE breast-feeding?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> months																				
	Primary occupation																					
5.11	(a) Respondent: <input type="checkbox"/>	(b) Spouse (if married): <input type="checkbox"/>																				
	1=At home doing housework 2=Unemployed, not seeking work: retired/ disabled 3=Unemployed, seeking work	4= Student/ training 5=Unskilled manual 6=Semi-skilled manual 7=Skilled manual																				
		8=Skilled non-manual 9=Semi-Professional 10=Professional																				

5.12	Briefly describe your job: _____	
Highest educational level attained		
5.13	(a) Respondent: <input type="checkbox"/>	(b) Spouse (if married) <input type="checkbox"/>
	1=Illiterate	4=Secondary school (ITI course, class X/XII, Intermediate)
	2=Literate, no formal education	5=Graduate (BA, BSc, BCom, Diploma)-completed
	3=Up to primary school (class IV)	6=Professional degree/postgraduate (MA, MSc, MBBS, MSW, BTech, PhD)
Now I am going to ask you some questions about your household		
Current household circumstances		
6.1	What kind of household do you currently live in?	<input type="checkbox"/>
	1=Single 2=Hostel/shared accommodation 3=Nuclear family (married couple & offspring) 4=Extended family (2 related married couples of different generations i.e. married couple with one of the parents)	5=Joint family (two related married couples from same generation (i.e. two married siblings) 6=Joint-extended 7=Any other
6.2	What is the material used in the construction of the house?	<input type="checkbox"/> 1=Kutcha 2=Semi-pucca 3=Pucca
6.3 a	What is the main source of lighting for your household?	<input type="checkbox"/> 1=Electricity 2=Kerosene 3=Gas 4=Oil 5=Other
6.3 b	What is the main source cooking fuel?	<input type="checkbox"/> 1=Electricity 2=Kerosene 3=Gas 4=Oil 5=Other
6.4	What is the main source of drinking water for members of your household?	<input type="checkbox"/> 1=Pipe, hand pump, well (in residence/ plot) 2=Pipe, hand pump or well (public) 3=Other
6.5	What kind of toilet facility does the household have?	<input type="checkbox"/> 1=Own flush toilet 2=Own pit toilet/latrine 3=No facility/field/bush 4=Other
6.6	Do you collect rations from a ration card?	<input type="checkbox"/> [1=Yes; 2=No]
SKIP QUESTIONS 6.7-6.10 IF LIVING IN HOSTEL/SHARED ACCOMMODATION		
6.7	Including yourself, how many people normally live in your household?	<input type="text"/> <input type="text"/> [Number of People]

6.8 a	How many rooms are there in your household? (count all rooms including kitchen, bathroom, etc)	<input type="text"/> <input type="text"/> [Number of Rooms]
6.8 b	Do you have a separate kitchen at home ?	<input type="checkbox"/> [1=Yes; 2=No]
6.8 c	If yes, for how many years ?	<input type="text"/> <input type="text"/>
6.9	Does this household own any agricultural land?	<input type="checkbox"/> [1=Yes; 2=No]
6.10	Does the household own any of the following:	
	(a) Clock/Watch	<input type="checkbox"/> [1=Yes; 2=No]
	(b) Radio/Transistor/Tape recorder	<input type="checkbox"/> [1=Yes; 2=No]
	(c) Television	<input type="checkbox"/> [1=Yes; 2=No]
	(d) Bicycle	<input type="checkbox"/> [1=Yes; 2=No]
	(e) Motorcycle/scooter/moped	<input type="checkbox"/> [1=Yes; 2=No]
	(f) Car	<input type="checkbox"/> [1=Yes; 2=No]
	(g) Refrigerator	<input type="checkbox"/> [1=Yes; 2=No]
	(h) Telephone	<input type="checkbox"/> [1=Yes; 2=No]
	(i) Water pump	<input type="checkbox"/> [1=Yes; 2=No]
	(j) Bullock cart	<input type="checkbox"/> [1=Yes; 2=No]
	(k) Thresher	<input type="checkbox"/> [1=Yes; 2=No]
	(l) Tractor	<input type="checkbox"/> [1=Yes; 2=No]

Now thinking back to when you were a child, say 10-12 years old, please answer the following questions about the household where you lived at that time		
Household circumstances in childhood (at age 10-12 years)		
7.1	What was your father's occupation at the time?	<input type="checkbox"/>
	1=At home doing housework 2=Unemployed, not seeking work: retired/ disabled 3=Unemployed, seeking work 4= Student/ training 5=Unskilled manual 6=Semi-skilled manual 7=Skilled manual 8=Skilled non-manual 9=Semi-Professional 10=Professional 11=Died, left family	
7.2	What was the highest educational level attained by your mother?	<input type="checkbox"/>

	<p>1=Illiterate</p> <p>2=Literate, no formal education</p> <p>3=Up to primary school (class IV)</p>	<p>4=Secondary school (ITI course, class X/XII, intermediate)</p> <p>5=Graduate (BA, BSc, B.Com, Diploma)</p> <p>6=Professional degree/postgraduate (MA, MSc, MBBS, MSW, B.Tech, PhD)</p>
7.3	<p>What was the highest educational level attained by your father?</p> <p><input type="checkbox"/></p>	<p>1=Illiterate</p> <p>2=Literate, no formal education</p> <p>3=Up to primary school (class IV)</p> <p>4=Secondary school (ITI course, class X/XII, Intermediate)</p> <p>5=Graduate (BA, BSc, BCom, Diploma)</p> <p>6=Professional degree/postgraduate (MA, MSc, MBBS, MSW, B.Tech, PhD)</p>
7.4	<p>What was your mother's occupation at the time</p> <p><input type="checkbox"/></p>	<p>1=At home doing housework</p> <p>2=Unemployed, not seeking work: retired/ disabled</p> <p>3=Unemployed, seeking work</p> <p>4= Student/ training</p> <p>5=Unskilled manual</p> <p>6=Semi-skilled manual</p> <p>7=Skilled manual</p> <p>8=Skilled non-manual</p> <p>9=Semi-Professional</p> <p>10=Professional</p> <p>11=Died, left family</p>
7.5	<p>What kind of household did you live in?</p> <p><input type="checkbox"/></p>	<p>1=Single</p> <p>2=Hostel/shared accommodation</p> <p>3=Nuclear family (married couple & offspring)</p> <p>4=Extended family (2 related married couples of different generations i.e. married couple with one of the parents)</p> <p>5=Joint family (two related married couples from same generation (i.e. two married siblings)</p> <p>6=Joint-extended</p> <p>7=Any other</p>
7.6	<p>What was the material used in the construction of the house?</p> <p><input type="checkbox"/></p>	<p>1=Kutchra</p> <p>2=Semi-pucca</p> <p>3=Pucca</p>
7.7a	<p>What was the main source of lighting for your household?</p> <p><input type="checkbox"/></p>	<p>1=Electricity</p> <p>2=Kerosene</p> <p>3=Gas</p> <p>4=Oil</p> <p>5=Other</p>
7.7b	<p>What was the main source cooking fuel?</p> <p><input type="checkbox"/></p>	<p>1=Electricity</p> <p>2=Kerosene</p> <p>3=Gas</p> <p>4=Oil</p> <p>5=Other</p>

7.8	What was the main source of drinking water for members of your household?	<input type="checkbox"/>	1=Pipe, hand pump, well (in residence/ plot) 2=Pipe, hand pump or well (public) 3=Other
7.9	What kind of toilet facility did the household have?	<input type="checkbox"/>	1=Own flush toilet 2=Own pit toilet/latrine 3=No facility/field/bush 4=Other
7.10	Did you collect rations from a ration card?	<input type="checkbox"/>	[1=Yes; 2=No]
SKIP QUESTIONS 7.11 -7.14 IF LIVING IN HOSTEL/SHARED ACCOMMODATION			
7.11	Including yourself, how many people normally lived in your household?	<input type="checkbox"/> <input type="checkbox"/>	[Number of People]
7.12 a	How many rooms were there in your household? (count all rooms including kitchen, bathroom, etc)	<input type="checkbox"/> <input type="checkbox"/>	[Number of Rooms]
7.12 b	Did you have separate kitchen at home?	<input type="checkbox"/>	[1=Yes; 2=No]
7.12 c	If yes , for how many years ?	<input type="checkbox"/> <input type="checkbox"/>	
7.13	Did this household own any agricultural land?	<input type="checkbox"/>	[1=Yes; 2=No]
7.14	Did the household own any of the following:		
	(a) Clock/Watch	<input type="checkbox"/>	[1=Yes; 2=No]
	(b) Radio / Transistor /Tape recorder	<input type="checkbox"/>	[1=Yes; 2=No]
	(c) Television	<input type="checkbox"/>	[1=Yes; 2=No]
	(d) Bicycle	<input type="checkbox"/>	[1=Yes; 2=No]
	(e) Motorcycle / scooter / moped	<input type="checkbox"/>	[1=Yes; 2=No]
	(f) Car	<input type="checkbox"/>	[1=Yes; 2=No]
	(g) Refrigerator	<input type="checkbox"/>	[1=Yes; 2=No]
	(h) Telephone	<input type="checkbox"/>	[1=Yes; 2=No]
	(i) Water pump/ motor	<input type="checkbox"/>	[1=Yes; 2=No]
	(j) Bullock cart	<input type="checkbox"/>	[1=Yes; 2=No]
	(k) Thresher	<input type="checkbox"/>	[1=Yes; 2=No]
	(l) Tractor	<input type="checkbox"/>	[1=Yes; 2=No]

Now I will ask you a few questions about your health and lifestyle

Health and lifestyle

8.1	(i) Have you ever used tobacco on a REGULAR basis (at least weekly)?	(ii) Age at starting	(iii) Duration of use	(iv) Number of days per week	(v) Number of use or smoked per day	(vi) Time of day when first cigarette is smoked
(a) Smoked	1=Never <input type="checkbox"/> 2=Former (stopped >6months) 3=Current (in last 6 months)	<input type="text"/> <input type="text"/> [Yrs]	<input type="text"/> <input type="text"/> [Yrs]	<input type="text"/> [Days]	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> a.m/p.m
(b) Chewed	1=Never <input type="checkbox"/> 2=Former (stopped >6months) 3=Current (in last 6 months)	<input type="text"/> <input type="text"/> [Yrs]	<input type="text"/> <input type="text"/> [Yrs]	<input type="text"/> [Days]	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> a.m/p.m
(c) Snuffed	1=Never <input type="checkbox"/> 2=Former (stopped >6months) 3=Current (in last 6 months)	<input type="text"/> <input type="text"/> [Yrs]	<input type="text"/> <input type="text"/> [Yrs]	<input type="text"/> [Days]	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> a.m/p.m
8.2	(a) Is there someone in your household who smokes tobacco at home? [If no, skip to 8.3] <input type="checkbox"/> [1=Yes; 2=No]					
	If yes, (b) How many cigarettes or beedis does this person smoke per day? <input type="text"/> <input type="text"/> <input type="text"/> beedis /cigarettes per day					
8.3	(a) Has an indoor open fire with wood, crop residues or dung been used in your home as a primary means of cooking for more than 6 months in your life? [If no, skip to 8.4] <input type="checkbox"/> [1=Yes; 2=No]					
	If yes, (b) For how many years has wood, crop residues or dung been used for cooking in your home? <input type="text"/> <input type="text"/> [Years]					
	(c) On average for how many hours a day have you personally spent cooking using wood, crop residues or dung? [00 if none] <input type="text"/> <input type="text"/> [Hours]					
	(d) Is wood, crop residues or dung still used for cooking in your home? <input type="checkbox"/> [1=Yes; 2=No]					

	(e) Was your stove or fire vented to the outside? <input type="checkbox"/> [1=Yes; 2=No]																					
8.4	Would you describe your present alcohol intake as? a. Locally made spirits b. Branded spirits c. Beer d. Wine	<input type="checkbox"/> 1=Daily/most days <input type="checkbox"/> 2=Weekends only <input type="checkbox"/> 3= 1-2 times/month <input type="checkbox"/> 4=Special occasions <input type="checkbox"/> 5=Never																				
8.4a	Measures or glasses per occasion a. Locally made spirits b. Branded spirits c. Beer d. Wine	No. of glasses <table style="display: inline-table; vertical-align: middle;"> <tr><td><input type="text"/></td><td><input type="text"/></td></tr> <tr><td><input type="text"/></td><td><input type="text"/></td></tr> <tr><td><input type="text"/></td><td><input type="text"/></td></tr> <tr><td><input type="text"/></td><td><input type="text"/></td></tr> </table> ml <table style="display: inline-table; vertical-align: middle;"> <tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr> <tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr> <tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr> <tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr> </table>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Now I will ask you a few questions about how you have been feeling in general. I will read out a list of statements, please tell me which one best describes your health state today.			
Quality of life			
9.1	Mobility	<input type="checkbox"/>	1= I have no problems in walking around; 2= I have some problems in walking around; 3=I am confined to bed
9.2	Self care	<input type="checkbox"/>	1= I have no problems with washing and dressing myself; 2= I have some problems with washing or dressing myself; 3=I am unable to wash and dress myself
9.3	Usual activities	<input type="checkbox"/>	(e.g. work, study, housework, family or leisure activities) 1= I have no problems with performing my usual activities; 2= I have some problems with performing my usual activities; 3=I am unable to perform my usual activities
9.4	Pain/discomfort	<input type="checkbox"/>	1= I have no pain or discomfort; 2= I have moderate pain or discomfort; 3=I have extreme pain or discomfort
9.5	Anxiety/Depression	<input type="checkbox"/>	1= I am not anxious or depressed; 2= I am moderately anxious or depressed; 3=I am extremely anxious or depressed
9.6	We have drawn a scale on which the best state you can imagine is marked 100 and the worst state you can imagine is marked 0. Please indicate on this scale how good or bad your own health is today, in your opinion		<input type="text"/> <input type="text"/> <input type="text"/> %
Depression			
	Over the last 2 weeks, how often have you been bothered by any of the following problems?	1=Not at all 2=Several days	3=More than half the days 4=Nearly every day
9.7	Little interest or pleasure in doing things	<input type="checkbox"/>	
9.8	Feeling down, depressed, or hopeless	<input type="checkbox"/>	
9.9	Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/>	
9.10	Feeling tired or having little energy	<input type="checkbox"/>	
9.11	Poor appetite or overeating	<input type="checkbox"/>	
9.12	Feeling bad about yourself, or that you are a failure, or have let yourself or your family down	<input type="checkbox"/>	
9.13	Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	
9.14	Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	<input type="checkbox"/>	
9.15	Thoughts that you would be better off dead, or of hurting yourself in some way	<input type="checkbox"/>	

9.16	In the last 4 weeks, have you had an anxiety attack – suddenly feeling fear or panic	<input type="checkbox"/> [1=Yes; 2=No]
IF NO, SKIP QUESTIONS 9.17-9.20 AND GO TO QUESTION 9.21		
	If yes,	
9.17	Has this happened before?	<input type="checkbox"/> [1=Yes; 2=No]
9.18	Do some of these attacks come suddenly out of the blue – that is, in situations where you don't expect to be nervous or uncomfortable?	<input type="checkbox"/> [1=Yes; 2=No]
9.19	Do these attacks bother you a lot or are you worried about having another attack?	<input type="checkbox"/> [1=Yes; 2=No]
9.20	During your last bad anxiety attack, did you have symptoms like shortness of breath, sweating, your heart racing or pounding, dizziness or faintness, tingling or numbness, or nausea or upset stomach?	<input type="checkbox"/> [1=Yes; 2=No]
9.21	If you checked off any problems on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	<input type="checkbox"/> 1=Not difficult at all 2=Somewhat difficult 3=Very difficult 4=Extremely difficult
In the last 4 weeks, how much have you been bothered by any of the following problems?		1=Not bothered 2=Bothered a little 3=Bothered a lot
9.22	Worrying about your health	<input type="checkbox"/>
9.23	Your weight or how you look	<input type="checkbox"/>
9.24	Difficulties with husband/wife, parents, or other relatives	<input type="checkbox"/>
9.25	The stress of taking care of children, parents or other family members	<input type="checkbox"/>
9.26	Stress at work outside of home or at school	<input type="checkbox"/>
9.27	Financial problems or worries	<input type="checkbox"/>
9.28	Having no one to turn to when you have a problem	<input type="checkbox"/>
9.29	Something bad that happened recently	<input type="checkbox"/>

9.30	Thinking or dreaming about something terrible that had happened to you in the past – like your house being destroyed, a severe accident, being hit or assaulted, or being forced to commit a sexual act	<input type="checkbox"/>
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Now I will ask you questions relating to your usual sleep patterns.		
10.1	How many hours do you usually sleep per day (including sleep at night and during the day) on a typical day when you have school or work the next day?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> [Completed half hours]
10.2	How many hours do you usually sleep per day (including sleep at night and during the day) on a typical day when you do not have school or work the next day?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> [Completed half hours]
10.3	(a) Do you undertake shift work that interrupts your usual sleep patterns?	<input type="checkbox"/> [1=Yes; 2=No]
	(b) If yes, how often is the shift work (over the last month)?	<input type="checkbox"/> 1=Daily <input type="checkbox"/> 2=5-6 times/week <input type="checkbox"/> 3=2-4 times/week <input type="checkbox"/> 4=Once a week <input type="checkbox"/> 5=2-3 times/month <input type="checkbox"/> 6=Once a month
10.4	In the past month, how often have you experienced difficulties in getting to sleep?	<input type="checkbox"/> 1=Daily <input type="checkbox"/> 2=5-6 times/week <input type="checkbox"/> 3=2-4 times/week <input type="checkbox"/> 4=Once a week <input type="checkbox"/> 5=2-3 times/month <input type="checkbox"/> 6=Once a month <input type="checkbox"/> 7=Never
10.5	In the past month, how often have you been bothered by awakening during night?	<input type="checkbox"/> 1=Daily <input type="checkbox"/> 2=5-6 times/week <input type="checkbox"/> 3=2-4 times/week <input type="checkbox"/> 4=Once a week <input type="checkbox"/> 5=2-3 times/month <input type="checkbox"/> 6=Once a month <input type="checkbox"/> 7=Never

PHYSICAL ACTIVITY QUESTIONNAIRE

	<p>Now I am going to ask you questions about the time you spent doing different types of physical activity. Please recall the activities that you did in the LAST WEEK.</p> <p>The first questions are about your work/college. This includes paid jobs, working in your farm, study/training, any volunteer work or college activities.</p> <p>Do not include unpaid work you might do around your home, like housework, garden work, and caring for your family. I will ask you about these later.</p>	
	Work related activity	
11.1	Do you currently have a job or do any unpaid work or study/training? Do not include household work, we will ask about this later.	<input type="checkbox"/> [1=Yes; 2=No] [IF NO, SKIP TO 11.8]
11.2	How many days did you work at the job or unpaid work in the last week?	<input type="checkbox"/> [In completed days]
11.3	In the last week, how many hours per day did you spend at this work?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	Of the hours you spend at work in a day during the last week I am going to ask you how many hours you spend in	

	standing, sitting, walking and other strenuous activities:		
	(a) Standing: E.g. talk, lab work, supervise, mild cleaning, cattle grazing done standing.	(b) Sitting: E.g. typing, computer work, cleaning grains, eating lunch, driving for your work, etc	(c) Walking: E.g. walking around, strolling, walking with light loads
	<input type="text"/> <input type="text"/> <input type="text"/> [hours]	<input type="text"/> <input type="text"/> <input type="text"/> [hours]	<input type="text"/> <input type="text"/> <input type="text"/> [hours]
11.4	If you spend any time at work on activities more strenuous than walking, please list these:		
		(i) Took part in this activity	(ii) Days per week
	(a) Carrying/walking with loads (15-25 kg)	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> days
	(b) Carrying/walking with heavy load (≥ 25 kg)	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> days
	(c) Lifting / loading of weights	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> days
	(d) Pushing cart with a load	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> days
	(e) Ploughing	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> days
	(f) Digging	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> days
	(g) Watering / weeding fields	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> days
	(h) Cut / chop wood or stones	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> days
	(i) Harvesting	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> days
	(j) Any others?	<input type="checkbox"/> [1=Yes; 2=No]	
	(k) _____		<input type="checkbox"/> days
	(l) _____		<input type="checkbox"/> days
	(m) _____		<input type="checkbox"/> days
	Travel to and from work Now think about how you travelled to and from work over the LAST WEEK. Please do not include travelling activities if you have already mentioned while we discussed your work/college activities.		
		(a) Days per week	(b) Total duration per day
11.5	During the last week, how many days did you travel on a motorised vehicle, like a car, bus, auto-rickshaw or motorcycle to and from work?	<input type="checkbox"/> days	<input type="text"/> <input type="text"/> <input type="text"/> [mts]
11.6	During the last week, on how many days did you cycle to and from work?	<input type="checkbox"/> days	<input type="text"/> <input type="text"/> <input type="text"/> [mts]

11.7	During the last week, on how many days did you walk to and from work?	<input type="text"/> days	<input type="text"/> <input type="text"/> <input type="text"/> [mts]	
<p>Travel apart from to and from work</p> <p>Now think about how you travelled from place to place over the LAST WEEK, including places like stores, movies, visiting relatives etc but excluding to and from work. Please do not include travelling activities if you have already mentioned.</p>				
		(a) Days per week	(b) Total duration per day	
11.8	During the last week, how many days did you travel to places on a motorised vehicle, like a car, bus, auto-rickshaw or motorcycle except to and from work?	<input type="text"/> days	<input type="text"/> <input type="text"/> <input type="text"/> [mts]	
11.9	During the last week, on how many days did you travel to places on a bicycle except to and from work?	<input type="text"/> days	<input type="text"/> <input type="text"/> <input type="text"/> [mts]	
11.10	During the last week, on how many days did you travel to places by walking except to and from work ?	<input type="text"/> days	<input type="text"/> <input type="text"/> <input type="text"/> [mts]	
<p>Now I am going to ask you some questions about how you spent your time, apart from work outside of the home over the LAST WEEK</p>				
11.11	<p>Sports / games / exercise</p> <p>Now think about all the physical activities that you did in the last 7 days solely for sport, exercise of leisure. Please do not include any activities you have already mentioned.</p>			
	Name of activity	(i) Took part in this activity	(ii) Days per week	(iii) Total duration per day
	(a) Walking normal speed for leisure	<input type="checkbox"/> [1=Yes; 2=No]	<input type="text"/> days	<input type="text"/> <input type="text"/> <input type="text"/> [mts]
	(b) Walking brisk speed for leisure	<input type="checkbox"/> [1=Yes; 2=No]	<input type="text"/> days	<input type="text"/> <input type="text"/> <input type="text"/> [mts]
	(c) Jogging/Running	<input type="checkbox"/> [1=Yes; 2=No]	<input type="text"/> days	<input type="text"/> <input type="text"/> <input type="text"/> [mts]
	(d) Badminton	<input type="checkbox"/> [1=Yes; 2=No]	<input type="text"/> days	<input type="text"/> <input type="text"/> <input type="text"/> [mts]
	(e) Cricket	<input type="checkbox"/> [1=Yes; 2=No]	<input type="text"/> days	<input type="text"/> <input type="text"/> <input type="text"/> [mts]
	(f) Yoga	<input type="checkbox"/> [1=Yes; 2=No]	<input type="text"/> days	<input type="text"/> <input type="text"/> <input type="text"/> [mts]
	(g) Swimming	<input type="checkbox"/> [1=Yes; 2=No]	<input type="text"/> days	<input type="text"/> <input type="text"/> <input type="text"/> [mts]
	(l) Volleyball	<input type="checkbox"/> [1=Yes; 2=No]	<input type="text"/> days	<input type="text"/> <input type="text"/> <input type="text"/> [mts]
	(j) Kabbadi	<input type="checkbox"/> [1=Yes; 2=No]	<input type="text"/> days	<input type="text"/> <input type="text"/> <input type="text"/> [mts]
	(k) Cycling	<input type="checkbox"/> [1=Yes; 2=No]	<input type="text"/> days	<input type="text"/> <input type="text"/> <input type="text"/> [mts]

	(m) Any others?	<input type="checkbox"/> [1=Yes; 2=No]		
	(n)		<input type="checkbox"/> days	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> [mts]
	(o)		<input type="checkbox"/> days	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> [mts]
	(p)		<input type="checkbox"/> days	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> [mts]
11.12	Household activities Now think about activities you do at home such as housework, gardening and hobbies. Please do not include any activities already mentioned.			
	Name of activity	(i) Took part in this activity	(ii) Days per week	(iii) Total duration per day
	(a) Cooking	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> days	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> [mts]
	(b) Washing vessels	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> days	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> [mts]
	(c) Mopping	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> days	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> [mts]
	(d) Sweeping	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> days	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> [mts]
	(e) Wash clothes manually	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> days	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> [mts]
	(f) Dusting / cleaning	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> days	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> [mts]
	(g) Ironing and folding clothes	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> days	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> [mts]
	(h) Child care	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> days	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> [mts]
	(i) Collecting fuel/fodder/water	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> days	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> [mts]
	(j) Animal care	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> days	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> [mts]
	(k) Gardening	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> days	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> [mts]
	(l) Any others?	<input type="checkbox"/> [1=Yes; 2=No]		
	(m) Washing clothes by machine	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> days	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> [mts]
	(n) _____		<input type="checkbox"/> days	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> [mts]
	(o) _____		<input type="checkbox"/> days	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> [mts]

11.13	Sedentary activities			
	The last question is about time spent sitting in the last 7 days. Do not include time spent sitting at work Please do not include any activities already mentioned.			
	Name of activity	(i) Took part in this activity	(ii) Days per week	(iii) Total duration per day
	(a) Reading for leisure	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> days	<input type="text"/> <input type="text"/> <input type="text"/> [mts]
	(b) Computer /computer games / internet for leisure	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> days	<input type="text"/> <input type="text"/> <input type="text"/> [mts]
	(c) Watching TV/ movies	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> days	<input type="text"/> <input type="text"/> <input type="text"/> [mts]
	(d) Indoor games (e.g. chess, carom, playing cards)	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> days	<input type="text"/> <input type="text"/> <input type="text"/> [mts]
	(e) Prayer/meditation	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> days	<input type="text"/> <input type="text"/> <input type="text"/> [mts]
	(f) Listening to music/radio	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> days	<input type="text"/> <input type="text"/> <input type="text"/> [mts]
	(g) Sewing /embroidery/ knitting	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> days	<input type="text"/> <input type="text"/> <input type="text"/> [mts]
	(h) Socialising (talking outside working hours or on phone)	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> days	<input type="text"/> <input type="text"/> <input type="text"/> [mts]
	(i) Any others?	<input type="checkbox"/> [1=Yes; 2=No]		
	(j) Sitting idle	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> days	<input type="text"/> <input type="text"/> <input type="text"/> [mts]
	(k) _____		<input type="checkbox"/> days	<input type="text"/> <input type="text"/> <input type="text"/> [mts]
11.14	Routine activities			
	Name of activity	(i) Took part in this activity	(ii) Days per week	(iii) Total duration per day
	(a) Eating (breakfast, lunch ,dinner)	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> days	<input type="text"/> <input type="text"/> <input type="text"/> [mts]
	(b) Brushing, shaving, bathing	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> days	<input type="text"/> <input type="text"/> <input type="text"/> [mts]
	(c) Dressing	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> days	<input type="text"/> <input type="text"/> <input type="text"/> [mts]

FOOD FREQUENCY QUESTIONNAIRE

INSTRUCTION TO SUBJECT: I am now going to ask you about the food that you have eaten over the last year. If you have not heard of an item please answer "No".							
	CEREALS	Portion Size	(a) Average consumption	(b) Per Day ¹	(b) Per Week ²	(b) Per Month ³	(b) Per Year/ Never ⁴
12.1	Chapathis / roti	No					
12.2	Parathas / naan	No					
12.3	Jowar roti	No					
12.4	Poori, bhatura	No					
12.5	Plain rice	Bowl					
12.6	Mutton, chicken biriyani	Bowl					
12.7	Lime rice, puliogare, veg biriyani	Bowl					
12.8	Bhagar	Bowl					
12.9	Upma	Bowl					
12.10	Idlis	No					
12.11	Dosa / uthappam	No					
12.12	Pesarattu	No					
12.13	Attakalu	Bowl					
12.14	Rice, ragi porridge	Bowl					
12.15	Corn flakes	Bowl					
12.16	Bread, Toast, Rolls, Buns	No					
12.17	Noodles, pasta etc	Bowl					
	LENTILS / DHALS / GRAVIES						
13.1	Plain dhal sambar	Ladle					
13.2	Dhal sambar with vegetables	Ladle					
13.3	Channa, rajma, dry peas etc. curry	Ladle					
13.4	Green leafy vegetable curry	Ladle					
13.5	Rasam, all types	Ladle					

		Portion Size	(a) Average consumption	(b) Per Day ¹	(b) Per Week ²	(b) Per Month ³	(b) Per Year/ Never ⁴
	CHUTNEYS / SALAD / PAPAD						
14.1	Raw vegetable salad	Tbsp					
14.2	Vegetable Raitha	Tbsp					
14.3	Pickle	Tsp					
14.4	Papad	No					
14.5	Coconut chutney	Tbsp					
14.6	Groundnut chutney	Tbsp					
14.7	Tomato chutney	Tbsp					
	NON – VEGETARIAN						
15.1	Chicken curry	Bowl					
15.2	Chicken fry/grilled	No					
15.3	Mutton/ pork/beef curry or fry	Bowl					
15.4	Fish curry	Bowl					
15.5	Fish fry	No					
15.6	Organ meats (Liver, brain, kidney etc.)	Tbsp					
15.7	Prawn, crab, shell fish etc.	Bowl					
15.8	Egg (boiled, poached, omelettes)	No					
	MILK & BEVERAGES						
16.1a.	Tea –with milk	Glass					
16.1b.	Tea –without milk	Glass					
16.2 a.	Coffee – with milk	Glass					
16.2 b.	Coffee-without milk	Glass					
16.3	Plain milk	Glass					
16.4	Flavored milk (horlicks, bournvita etc)	Glass					
16.5	Curds	Bowl					
16.6	Buttermilk/Lassi	Glass					
16.7	Lime/ orange/ other fresh fruit juice	Glass					

		Portion Size	(a) Average consumption	(b) Per Day ¹	(b) Per Week ²	(b) Per Month ³	(b) Per Year/ Never ⁴
16.8	Fanta, pepsi, coca cola etc.	250ml bottle					
16.9	Beer	Bottle					
16.10	Spirits (whiskey, gin, rum, arrack)	30ml peg					
16.11	Other local alcoholic drinks	30ml peg					
	MISCELLANEOUS						
17.1	Ghee/ butter	Tsp					
17.2	Jam	Tsp					
17.3	Sugar	Tsp					
17.4	Salt	Tsp					
	SNACKS/ SWEETS/DESSERTS						
18.1	Mixture, namkeen, chiwda, khara boondi, dalmoth	Tbsp					
18.2	Vada, all types	No					
18.3	Nuts (groundnuts, cashewnuts etc.)	Tbsp					
18.4	Chips/salted packed snacks (bingo, kurkure etc)	Bowl					
18.5	Samosa, bajji, bonda, cutlet, patties	No					
18.6	Salted biscuits (krackjack, bakery biscuits)	No					
18.7	Sweet biscuits (Marie/good day/cream biscuits)	No					
18.8	Murukku, chakli, sakinalu	No					
18.9	Cakes or sweet pastries	No					
18.10	Payasam, kheer	Bowl					
18.11	Ice cream	Bowl					

		Portion Size	(a) Average consumption	(b) Per Day ¹	(b) Per Week ²	(b) Per Month ³	(b) Per Year/ Never ⁴
18.12	Jamoon, Jilebi, Jangir etc.	No					
18.13	Mysore pak, laddoo, barfis	No					
18.14	Baksham	No					
18.15	Dried fruits (dates, figs, raisins etc)	Tbsp					
18.16	Chocolates	Small Bar					

	FRUITS	Portion size	(a) Average consumption	(b) Per Day ¹	(b) Per Week ²	(b) Per Month ³	(b) Per Year/ Never ⁴	(c) Seasonal (cross if seasonal)
19.1	Banana	No						
19.2	Apple	No						
19.3	Orange	No						
19.4	Mango	No						
19.5	Guava (amrood)	No						
19.6	Grapes (angoor)	Bowl						
19.7	Pineapple	Slice						
19.8	Papaya (papita)	Slice						
19.9	Pomegranate (anar)	No						
19.10	Sapota (Chikoo)	No						
19.11	Watermelon(tarbooj)	Bowl						
19.12	Musk melon (kharbooj)	Bowl						
19.13	Custard apple	No						
19.14	Zizyphus (ber)	No						
19.15	Sugarcane (ganaa)	Pieces						
19.16	Palmyra	No						
	VEGETABLES							
20.1	Palak, methi, other leafy vegetables	Tbsp						
20.2	Potato, sweet potato	Tbsp						

20.3	Beetroot/ radish	Tbsp						
20.4	Cabbage	Tbsp						
20.5	Beans, cluster beans	Tbsp						
		Portion size	(a) Average consumption	(b) Per Day ¹	(b) Per Week ²	(b) Per Month ³	(b) Per Year/ Never ⁴	(c) Seasonal (cross if seasonal)
20.6	Ladies finger	Tbsp						
20.7	Cauliflower	Tbsp						
20.8	Bottlegourd (lauki), ashgourd, Ridgegourd (turai), snakegourds, etc.	Tbsp						
20.9	Brinjal	Tbsp						
20.10	Kovai	Tbsp						
20.11	Capsicum/ green pepper	Tbsp						
20.12	Drumstick	Pieces						
20.13	Raw plantain	Tbsp						
20.14	Colacasia (arvi)	Tbsp						

21.1	Which type of oil is consumed most by your family? State in order of decreasing quantity of use.	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Quantity in Kg/month 1=Sunflower oil <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> 2=Groundnut oil <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> 3=Coconut oil <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> 4=Palm oil <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> 5=Mustard oil <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> 6=Dalda /vanaspathi <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>	7=Butter <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> 8=Ghee <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> 9=Olive oil <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <hr/> 10=Corn <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> 11=Rice bran oil <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> 12=Soya bean oil <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> 13=Cotton seed oil <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>
21.2	How many coconuts do you use for cooking in a month?	<input type="text"/> <input type="text"/> [No / month] [00 if none]		
21.3	(a) What type of milk do you regularly consume?	<input type="checkbox"/>	1=Whole milk	4=Skimmed milk powder

			2=Skimmed milk 3=Toned milk	5=Whole and toned milk 6=Other
	(b) If other, then specify _____			
21.4	(a) Do you consume any vitamin or mineral supplement <input type="checkbox"/> [1=Yes; 2=No] at least once a week?			
	If Yes, (b) Brand name / Type	(c) Dosage(mg)	(d) No. / week	
21.5	Are you vegetarian? <input type="checkbox"/> [1=Yes; 2=No]			
21.6	Are you on any of the following special diets?			
	(a) Diabetic diet	<input type="checkbox"/> [1=Yes; 2=No]		
	(b) Low fat diet	<input type="checkbox"/> [1=Yes; 2=No]		
	(c) High fiber diet	<input type="checkbox"/> [1=Yes; 2=No]		
	(d) Low salt diet	<input type="checkbox"/> [1=Yes; 2=No]		
	(e) Weight reducing diet	<input type="checkbox"/> [1=Yes; 2=No]		
	(f) Other	<input type="checkbox"/> [1=Yes; 2=No]		
	(g) If other, please specify	1. 2.		
	If yes, (h) Since how many years are you on this special diet?	1. <input type="checkbox"/> <input type="checkbox"/> [completed years] 2. <input type="checkbox"/> <input type="checkbox"/> [completed years]		

Now I am going to ask you questions about your family history of illness, and your medical history				
Medical history				
22.16	Is your father still alive?	(a) <input type="checkbox"/> [1=Yes; 2=No]	(b) If no, his age at death <input type="checkbox"/> <input type="checkbox"/> [years]	
22.17	(a) If no, what was the cause of his death?	<input type="checkbox"/>	1=Heart disease 2=High blood Pressure 3=stroke	4=lung 5=cancer 6=accident /injury 7=other 8=don't know
	(b) If "other" specify:			

	Did/does your father suffer from any of the following?	
22.18	Diabetes	<input type="checkbox"/> [1=Yes; 2=No; 3=Don't know]
22.19	High blood pressure	<input type="checkbox"/> [1=Yes; 2=No; 3=Don't know]
22.19a.	Stroke	<input type="checkbox"/> [1=Yes; 2=No; 3=Don't know]
22.20	Heart disease	<input type="checkbox"/> [1=Yes; 2=No; 3=Don't know]
22.21	Overweight / obesity	<input type="checkbox"/> [1=Yes; 2=No; 3=Don't know]
22.22	Lung disease	<input type="checkbox"/> [1=Yes; 2=No; 3=Don't know]
22.23	Is your mother still alive?	(a) <input type="checkbox"/> [1=Yes; 2=No] (b) If no, her age at death <input type="checkbox"/> <input type="checkbox"/> [years]
22.24	(a) If no, what was the cause of her death?	<input type="checkbox"/> 1=Heart disease 4=lung 2=High blood Pressure 5=cancer 7=other 3=stroke 6=accident /injury 8=don't know
	(b) If "other" specify:	
	Did/does your mother suffer from any of the following?	
22.25	Diabetes	<input type="checkbox"/> [1=Yes; 2=No; 3=Don't know]
22.26	High blood pressure	<input type="checkbox"/> [1=Yes; 2=No; 3=Don't know]
22.26a	Stroke	<input type="checkbox"/> [1=Yes; 2=No; 3=Don't know]
22.27	Heart disease	<input type="checkbox"/> [1=Yes; 2=No; 3=Don't know]
22.28	Overweight/obesity	<input type="checkbox"/> [1=Yes; 2=No; 3=Don't know]
22.29	Lung disease	<input type="checkbox"/> [1=Yes; 2=No; 3=Don't know]
	Did/do any of your brothers or sisters suffer from any of the following?	
22.30	Diabetes	<input type="checkbox"/> [1=Yes; 2=No; 3=Don't know; 4=no siblings]
22.31	High blood pressure	<input type="checkbox"/> [1=Yes; 2=No; 3=Don't know; 4=no siblings]
22.31a	Stroke	<input type="checkbox"/> [1=Yes; 2=No; 3=Don't know]
22.32	Heart disease	<input type="checkbox"/> [1=Yes; 2=No; 3=Don't know; 4=no siblings]
22.33	Overweight/obesity	<input type="checkbox"/> [1=Yes; 2=No; 3=Don't know; 4=no siblings]
22.34	Lung disease	<input type="checkbox"/> [1=Yes; 2=No; 3=Don't know; 4=no siblings]
23.1	(a) Have you had wheezing or whistling in your chest at any time in the last year?	<input type="checkbox"/> [1=Yes; 2=No]
	If yes, (b) In the last year have you had this wheezing or whistling only when you have a cold?	<input type="checkbox"/> [1=Yes; 2=No]
	(c) In the last year have you ever had an attack of wheezing or whistling that has made you feel short of breath?	<input type="checkbox"/> [1=Yes; 2=No]

24.1	(a) Do you usually cough when you don't have a cold? [If no, skip to 24.2]	<input type="checkbox"/> [1=Yes; 2=No]
	If yes (b) Are there months when you cough most days	<input type="checkbox"/> [1=Yes; 2=No]
	(c) Do you have a cough on most days for as much as three months each year?	<input type="checkbox"/> [1=Yes; 2=No]
	(d) For how many years have you had this cough?	<input type="checkbox"/> <input type="checkbox"/> [Years]
24.2	(a) Do you usually bring up phlegm from your chest, or do you usually have phlegm in your chest that is difficult to bring up when you don't have a cold? [If no, skip to 24.3]	<input type="checkbox"/> [1=Yes; 2=No]
	If yes, (b) Are there months in which you have this phlegm on most days?	<input type="checkbox"/> [1=Yes; 2=No]
	(c) Do you bring up this phlegm on most days for as much as 3 months per year?	<input type="checkbox"/> [1=Yes; 2=No]
	(d) For how many years have you had this phlegm?	<input type="checkbox"/> <input type="checkbox"/> [Years]
24.3	(a) Are you unable to walk due to a condition other than shortness of breath? [If no, skip to 24.4]	<input type="checkbox"/> [1=Yes; 2=No]
	(b) If yes, name of condition _____	
24.4	If able to walk: (a) Are you troubled by shortness of breath when hurrying on the level or walking up a slight hill? [If no, skip to 24.5]	<input type="checkbox"/> [1=Yes; 2=No]
	If yes, (b) Do have to walk slower than most people of your age on level ground because of shortness of breath?	<input type="checkbox"/> [1=Yes; 2=No]
	(c) Do you have to stop for breath when walking at your own pace on level ground?	<input type="checkbox"/> [1=Yes; 2=No]
	(d) Do you ever have to stop for breath after walking about 100 yards on level ground?	<input type="checkbox"/> [1=Yes; 2=No]
	(e) Are you too short of breath to leave the house or short of breath on dressing of undressing?	<input type="checkbox"/> [1=Yes; 2=No]
24.5	(a) Have you ever had any pain or discomfort in your chest? [If no, end section]	<input type="checkbox"/> [1=Yes; 2=No]
	If yes, (b) Do you get it when you walk uphill or hurry?	<input type="checkbox"/> [1=Yes; 2=No]
	(c) Do you get it when you walk at an ordinary pace on the level?	<input type="checkbox"/> [1=Yes; 2=No]
	If no pain on walking, end section. Otherwise ask d-g	
	(d) What do you do if you get it while you are walking?	<input type="checkbox"/> 1=Stop/slow down 2=Carry on
	(e) If you are standing still, what happens to it?	<input type="checkbox"/> 1=Relieved 2=Not relieved
	(f) How soon?	<input type="checkbox"/> 1=10 minutes or less 2=Over 10 minutes
	(g) Will you show me where it is (record all places)? [SHOW PICTURE]	<input type="checkbox"/> , <input type="checkbox"/> , <input type="checkbox"/> , <input type="checkbox"/>

SECTION D: Anthropometry

Weight and height		a) First reading		b) Second reading					
25.1	Weight	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> [kg]	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> [kg]	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> [kg]	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> [kg]				
25.2	Scale number	<input type="text"/>							
25.3	Standing height	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> [mm]	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> [mm]	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> [mm]	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> [mm]				
25.4	Sitting height	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> [mm]	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> [mm]	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> [mm]	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> [mm]				
25.5	Stool height	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> [mm]	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> [mm]	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> [mm]	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> [mm]				
25.6	Stadiometer number	<input type="text"/>							
Circumferences		a) First reading		b) Second reading					
25.7	Waist circumference	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> [mm]	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> [mm]	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> [mm]	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> [mm]				
25.8	Hip circumference	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> [mm]	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> [mm]	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> [mm]	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> [mm]				
25.9	Mid-arm circumference	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> [mm]	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> [mm]	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> [mm]	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> [mm]				
25.10	Calf circumference	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> [mm]	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> [mm]	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> [mm]	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> [mm]				
25.11	Head circumference	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> [mm]	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> [mm]	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> [mm]	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> [mm]				
25.11- i	Chest Circumference at end-inspiration	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> [mm]	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> [mm]	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> [mm]	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> [mm]				
25.11- ii	Chest Circumference at end- expiration	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> [mm]	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> [mm]	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> [mm]	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> [mm]				
Skinfold measurements		a) First reading		b) Second reading		c) Third reading			
25.12	Triceps skinfold	<input type="text"/> <input type="text"/> . <input type="text"/> [mm]	<input type="text"/> <input type="text"/> . <input type="text"/> [mm]	<input type="text"/> <input type="text"/> . <input type="text"/> [mm]	<input type="text"/> <input type="text"/> . <input type="text"/> [mm]	<input type="text"/> <input type="text"/> . <input type="text"/> [mm]	<input type="text"/> <input type="text"/> . <input type="text"/> [mm]		
25.13	Biceps skinfold	<input type="text"/> <input type="text"/> . <input type="text"/> [mm]	<input type="text"/> <input type="text"/> . <input type="text"/> [mm]	<input type="text"/> <input type="text"/> . <input type="text"/> [mm]	<input type="text"/> <input type="text"/> . <input type="text"/> [mm]	<input type="text"/> <input type="text"/> . <input type="text"/> [mm]	<input type="text"/> <input type="text"/> . <input type="text"/> [mm]		
25.14	Subscapular skinfold	<input type="text"/> <input type="text"/> . <input type="text"/> [mm]	<input type="text"/> <input type="text"/> . <input type="text"/> [mm]	<input type="text"/> <input type="text"/> . <input type="text"/> [mm]	<input type="text"/> <input type="text"/> . <input type="text"/> [mm]	<input type="text"/> <input type="text"/> . <input type="text"/> [mm]	<input type="text"/> <input type="text"/> . <input type="text"/> [mm]		
25.15	Suprailiac skinfold	<input type="text"/> <input type="text"/> . <input type="text"/> [mm]	<input type="text"/> <input type="text"/> . <input type="text"/> [mm]	<input type="text"/> <input type="text"/> . <input type="text"/> [mm]	<input type="text"/> <input type="text"/> . <input type="text"/> [mm]	<input type="text"/> <input type="text"/> . <input type="text"/> [mm]	<input type="text"/> <input type="text"/> . <input type="text"/> [mm]		
25.16	Calf skinfold	<input type="text"/> <input type="text"/> . <input type="text"/> [mm]	<input type="text"/> <input type="text"/> . <input type="text"/> [mm]	<input type="text"/> <input type="text"/> . <input type="text"/> [mm]	<input type="text"/> <input type="text"/> . <input type="text"/> [mm]	<input type="text"/> <input type="text"/> . <input type="text"/> [mm]	<input type="text"/> <input type="text"/> . <input type="text"/> [mm]		
25.17	Caliper number	<input type="text"/>							
Muscle strength		Reading 1		Reading 2		Reading 3		Reading 4	
25.18	Right hand	<input type="text"/> <input type="text"/> . <input type="text"/> [kg]	<input type="text"/> <input type="text"/> . <input type="text"/> [kg]	<input type="text"/> <input type="text"/> . <input type="text"/> [kg]	<input type="text"/> <input type="text"/> . <input type="text"/> [kg]	<input type="text"/> <input type="text"/> . <input type="text"/> [kg]	<input type="text"/> <input type="text"/> . <input type="text"/> [kg]	<input type="text"/> <input type="text"/> . <input type="text"/> [kg]	<input type="text"/> <input type="text"/> . <input type="text"/> [kg]
25.19	Left hand	<input type="text"/> <input type="text"/> . <input type="text"/> [kg]	<input type="text"/> <input type="text"/> . <input type="text"/> [kg]	<input type="text"/> <input type="text"/> . <input type="text"/> [kg]	<input type="text"/> <input type="text"/> . <input type="text"/> [kg]	<input type="text"/> <input type="text"/> . <input type="text"/> [kg]	<input type="text"/> <input type="text"/> . <input type="text"/> [kg]	<input type="text"/> <input type="text"/> . <input type="text"/> [kg]	<input type="text"/> <input type="text"/> . <input type="text"/> [kg]
25.20	Dominant hand	<input type="text"/> [1=Right, 2=Left]							
25.21	Grip strength machine	<input type="text"/>							

General information: anthropometry measurements		
25.22	Researcher code	<input type="text"/> <input type="text"/>
25.23	Researcher initials	<input type="text"/> <input type="text"/> <input type="text"/>
25.24	Left sided measurements	<input type="checkbox"/> [1=Yes; 2=No]
25.25	If not, specify	
25.26	All measurements adequate	<input type="checkbox"/> [1=Yes; 2=No]
25.27	If not, specify	

Blood pressure				
26.1	Room temperature	<input type="text"/> <input type="text"/> . <input type="text"/> [degree Celsius]		
		a) First measure	b) Second measure	b) Third measure
26.2	Systolic BP (brachial)	<input type="text"/> <input type="text"/> <input type="text"/> [mmHg]	<input type="text"/> <input type="text"/> <input type="text"/> [mmHg]	<input type="text"/> <input type="text"/> <input type="text"/> [mmHg]
26.3	Diastolic BP (brachial)	<input type="text"/> <input type="text"/> <input type="text"/> [mmHg]	<input type="text"/> <input type="text"/> <input type="text"/> [mmHg]	<input type="text"/> <input type="text"/> <input type="text"/> [mmHg]
26.4	Pulse rate	<input type="text"/> <input type="text"/> <input type="text"/> [bpm]	<input type="text"/> <input type="text"/> <input type="text"/> [bpm]	<input type="text"/> <input type="text"/> <input type="text"/> [bpm]
26.5	Cuff size used	<input type="checkbox"/> [1=Small; 2=Medium; 3=Large]		
26.6	BP apparatus number	<input type="checkbox"/>		
26.7	Right arm measurements	<input type="checkbox"/> [1=Yes; 2=No]		
26.8	Measurements adequate	<input type="checkbox"/> [1=Yes; 2=No]		
26.9	If not, specify			
	Respiratory function			

27.1a	In the past three months have you had any surgery on your chest or abdomen?		<input type="checkbox"/> [1=Yes; 2=No]				
27.1b	Have you had a hernia problem at any time?		<input type="checkbox"/> [1=Yes; 2=No]				
27.2	Have you had a heart attack within the past three months?		<input type="checkbox"/> [1=Yes; 2=No]				
27.3	Do you have a detached retina or have you had eye surgery within the past three months?		<input type="checkbox"/> [1=Yes; 2=No]				
27.4	Have you been hospitalized with any other heart problem within the past month?		<input type="checkbox"/> [1=Yes; 2=No]				
27.5	Are you in the last trimester of pregnancy?		<input type="checkbox"/> [1=Yes; 2=No]				
27.6	Are you currently taking medication for TB?		<input type="checkbox"/> [1=Yes; 2=No]				
27.7	Have you coughed up blood within the past month?		<input type="checkbox"/> [1=Yes; 2=No]				
27.8	Does the participant have a resting pulse of greater than 120 beats per minute?		<input type="checkbox"/> [1=Yes; 2=No]				
If any of the questions 27.1 to 27.8 is "yes", do NOT proceed with the test							
27.9	(a) Have you taken medication for breathing in last 6 hours?		<input type="checkbox"/> [1=Yes; 2=No]				
If yes, name of medication: _____							
27.10	Have you had a respiratory infection (cold) in the last three weeks?		<input type="checkbox"/> [1=Yes; 2=No]				
TAKE VERBAL CONSENT TO DO THE TEST							
		Pred. value	a) Blow 1	b) Blow 2	c) Blow 3	d) Blow 4	e) Blow 5
27.11	F E V 1		<input type="text"/> . <input type="text"/> <input type="text"/> [I]	<input type="text"/> . <input type="text"/> <input type="text"/> [I]	<input type="text"/> . <input type="text"/> <input type="text"/> [I]	<input type="text"/> . <input type="text"/> <input type="text"/> [I]	<input type="text"/> . <input type="text"/> <input type="text"/> [I]
27.12	F V C		<input type="text"/> . <input type="text"/> <input type="text"/> [I]	<input type="text"/> . <input type="text"/> <input type="text"/> [I]	<input type="text"/> . <input type="text"/> <input type="text"/> [I]	<input type="text"/> . <input type="text"/> <input type="text"/> [I]	<input type="text"/> . <input type="text"/> <input type="text"/> [I]
27.13	If unable to obtain satisfactory spirometry (check one):			<input type="checkbox"/> 1 = Participant did not understand instructions <input type="checkbox"/> 2 = Participant medically excluded <input type="checkbox"/> 3 = Participant unable to physically cooperate <input type="checkbox"/> 4 = Participant refused			

ONLY FOR WOMEN

Now I will ask you a few questions about your reproductive history (women only)		
Reproductive history		
28.1	At what age did your periods start?	<input type="text"/> <input type="text"/> [Age in completed years]
28.2	(a) Do you still menstruate?	<input type="checkbox"/> [1=Yes; 2=No]
	(b) If no, at what age did your periods stop?	<input type="text"/> <input type="text"/> [Age in completed years]
	(c) If yes, do you have irregular/infrequent menstrual cycles?	<input type="checkbox"/> [1=Yes; 2=No]
	(d) If yes, how many periods do you have in a year?	<input type="text"/> <input type="text"/> [Number]
28.3	Do you have excess hair growth on your upper lip, chin, lower abdomen or inner thighs?	<input type="checkbox"/> [1=Yes; 2=No]
28.4	(a) Have you ever taken the oral contraceptive pill?	<input type="checkbox"/> [1=Yes; 2=No]
	(b) If yes, Which type of pill did you take	<input type="text"/> <input type="text"/> 1=Combined pill 2=Progestogen only (mini pill) 3=Don't know
	(c) If yes, for how long did you take it?	<input type="text"/> <input type="text"/> [Completed years]
28.5	(a) Have you ever been pregnant?	<input type="checkbox"/> [1=Yes; 2=No]
	(b) If yes, at what age was your first pregnancy?	<input type="text"/> <input type="text"/> [Age in completed years]
	(c) If yes, how many pregnancies have you had?	<input type="text"/> <input type="text"/> [Total number, 00 if none]
	(d) If yes, how many live births have you had?	<input type="text"/> <input type="text"/> [Total number, 00 if none]
	(e) If yes, how many miscarriages/stillbirths have you had?	<input type="text"/> <input type="text"/> [Total number, 00 if none]
	(f) If yes, how many induced abortions have you had?	<input type="text"/> <input type="text"/> [Total number, 00 if none]
		[Check that c = d + e + f]
28.6	Have you ever tried to become pregnant during a period of one year or more without success?	<input type="checkbox"/> [1=Yes; 2=No]
28.7	(a) Are you pregnant at the moment?(Ask if relevant to the sibling)	<input type="checkbox"/> [1=Yes; 2=No]
	(b) If yes, which trimester of pregnancy are you in?	<input type="checkbox"/> [1, 2 or 3]
3.2b.	Time of quest. Completion	<input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> [Hours: minutes; 24-hour clock]

SECTION E: DXA Measurements

DXA Scan		
29.1	DXA machine	<input type="checkbox"/> [1=New; 2=Old]
29.2	Researcher initials	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
29.3	Whole scan taken	<input type="checkbox"/> [1=Yes; 2=No]
29.4	Spine scan taken	<input type="checkbox"/> [1=Yes; 2=No]
29.5	Hip scan taken	<input type="checkbox"/> [1=Yes; 2=No]
29.6	If not, specify reason	<hr/>
29.7	First L1-L4 measure taken	<input type="checkbox"/> [1=Yes; 2=No]
29.8	Second L1-L4 measure taken	<input type="checkbox"/> [1=Yes; 2=No]
29.9	First L2-L4 measure taken	<input type="checkbox"/> [1=Yes; 2=No]
29.10	Second L2-L4 measure taken	<input type="checkbox"/> [1=Yes; 2=No]
29.11	If not, specify reason	<hr/>

SECTION F: Coronary Measures and Medical History

Medical history.	
30.1	(a) Have you been diagnosed with any of the following conditions? (b) <i>If yes</i> , age when diagnosed
30.2	High blood pressure (a) <input type="checkbox"/> [1=Yes; 2=No] (b) <input type="checkbox"/> <input type="checkbox"/> [Age in completed years]
	(c) Are you on regular medication for your high blood pressure? <input type="checkbox"/> [1=Yes; 2=No]
	(d) Name of medicine: _____
	(e) Who diagnosed condition <input type="checkbox"/> [1=allopathic doctor; 2=homeopath; 3=ayurvedic doctor 4=RMP – registered medical practitioner; 5=Other]
30.3	Diabetes (high blood sugar) (a) <input type="checkbox"/> [1=Yes; 2=No] (b) <input type="checkbox"/> <input type="checkbox"/> [Age in completed years]
	(c) Are you on a regular diet for your diabetes? <input type="checkbox"/> [1=Yes; 2=No]
	(d) Are you on regular tablets for your diabetes? <input type="checkbox"/> [1=Yes; 2=No]
	(e) Name of medicine: _____
	(f) Are you on a regular treatment with insulin? <input type="checkbox"/> [1=Yes; 2=No]
	(g) Do you attend a hospital or GP diabetic clinic? <input type="checkbox"/> [1=Yes; 2=No]
	(h) Who diagnosed condition <input type="checkbox"/> [1=allopathic doctor; 2=homeopath; 3=ayurvedic doctor 4=RMP – registered medical practitioner; 5=Other]
30.4	Heart disease (a) <input type="checkbox"/> [1=Yes; 2=No] (b) <input type="checkbox"/> <input type="checkbox"/> [Age in completed years]
	(c) Are you on regular medication for your heart disease? <input type="checkbox"/> [1=Yes; 2=No]
	(d) Name of medicine: _____
	(e) Who diagnosed condition <input type="checkbox"/> [1=allopathic doctor; 2=homeopath; 3=ayurvedic doctor 4=RMP – registered medical practitioner; 5=Other]
	(f) Type of heart disease <input type="checkbox"/> [1=angina; 2=heart attack; 3=heart failure 4=don't know; 5=Other]
30.5	Stroke (paralytic attack) (a) <input type="checkbox"/> [1=Yes; 2=No] (b) <input type="checkbox"/> <input type="checkbox"/> [Age in completed years]
	(c) Who diagnosed condition <input type="checkbox"/> [1=allopathic doctor; 2=homeopath; 3=ayurvedic doctor 4=RMP – registered medical practitioner; 5=Other]
30.6	Asthma, asthmatic bronchitis or allergic bronchitis? (a) <input type="checkbox"/> [1=Yes; 2=No] (b) <input type="checkbox"/> <input type="checkbox"/> [Age in completed years]
	(c) Have you had an attack of asthma in the last year? <input type="checkbox"/> [1=Yes; 2=No]
	(d) <i>If you have asthma</i> , are you on regular medication for asthma? (tablets/inhaler) <input type="checkbox"/> [1=Yes; 2=No]
	(e) Name of medicine: _____

30.7	Thyroid problem	(a) <input type="checkbox"/> [1=Yes; 2=No]	(b) <input type="checkbox"/> <input type="checkbox"/> [Age in completed years]
	(c) Are you on regular medication for your thyroid problem?		<input type="checkbox"/> [1=Yes; 2=No]
	(d) Name of medicine:	_____	
30.8	Tuberculosis	(a) <input type="checkbox"/> [1=Yes; 2=No]	(b) <input type="checkbox"/> <input type="checkbox"/> [Age in completed years]
	(c) Are you on regular medication for your tuberculosis?		<input type="checkbox"/> [1=Yes; 2=No]
	(d) Name of medicine:	_____	
30.9	Depression	(a) <input type="checkbox"/> [1=Yes; 2=No]	(b) <input type="checkbox"/> <input type="checkbox"/> [Age in completed years]
	(c) Are you on regular medication for your depression?		<input type="checkbox"/> [1=Yes; 2=No]
	(d) Name of medicine:	_____	
30.10	Peptic ulcer	(a) <input type="checkbox"/> [1=Yes; 2=No]	(b) <input type="checkbox"/> <input type="checkbox"/> [Age in completed years]
30.11	COPD	(a) <input type="checkbox"/> [1=Yes; 2=No]	(b) <input type="checkbox"/> <input type="checkbox"/> [Age in completed years]
30.12	Emphysema	(a) <input type="checkbox"/> [1=Yes; 2=No]	(b) <input type="checkbox"/> <input type="checkbox"/> [Age in completed years]
30.13	Chronic bronchitis	(a) <input type="checkbox"/> [1=Yes; 2=No]	(b) <input type="checkbox"/> <input type="checkbox"/> [Age in completed years]
30.14	Cancer	(a) <input type="checkbox"/> [1=Yes; 2=No]	(b) <input type="checkbox"/> <input type="checkbox"/> [Age in completed years]
	(c) <i>If yes, what type of cancer:</i>	_____	

MEDICAL EXAMINATION

	Carotid IMT	(a) Far wall	(b) Near wall
31.1	Right common carotid artery image taken	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> [1=Yes; 2=No]
31.2	Any problems taking images	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> [1=Yes; 2=No]
31.3	If yes, specify reason	_____	_____

Pulse Wave Velocity				
32.1	Room temperature	<input type="text"/> <input type="text"/> . <input type="text"/> [degree Celsius]		
32.2	Have you had a meal in last 2 hours?	<input type="text"/> [1=Yes; 2=No]		
32.3	Proximal distance (carotid to notch)	<input type="text"/> <input type="text"/> . <input type="text"/> [cm]		
32.4	Distal distance (notch to upper thigh)	<input type="text"/> <input type="text"/> . <input type="text"/> [cm]		
		(a) First measure	(b) Second measure	(c) Third measure
32.5	Systolic BP (supine)	<input type="text"/> <input type="text"/> <input type="text"/> [mmHg]	<input type="text"/> <input type="text"/> <input type="text"/> [mmHg]	<input type="text"/> <input type="text"/> <input type="text"/> [mmHg]
32.6	Diastolic BP (supine)	<input type="text"/> <input type="text"/> <input type="text"/> [mmHg]	<input type="text"/> <input type="text"/> <input type="text"/> [mmHg]	<input type="text"/> <input type="text"/> <input type="text"/> [mmHg]
32.7	Pulse rate (supine)	<input type="text"/> <input type="text"/> <input type="text"/> [bpm]	<input type="text"/> <input type="text"/> <input type="text"/> [bpm]	<input type="text"/> <input type="text"/> <input type="text"/> [bpm]
32.8	Pulse wave velocity	<input type="text"/> <input type="text"/> . <input type="text"/> [m/s]	<input type="text"/> <input type="text"/> . <input type="text"/> [m/s]	<input type="text"/> <input type="text"/> . <input type="text"/> [m/s]
32.9	Transit time	<input type="text"/> <input type="text"/> <input type="text"/> [ms]	<input type="text"/> <input type="text"/> <input type="text"/> [ms]	<input type="text"/> <input type="text"/> <input type="text"/> [ms]
Pulse Wave Analysis				
32.10	Distance (brachial to femoral)	<input type="text"/> <input type="text"/> . <input type="text"/> [cm]		
		(a) First measure	(b) Second measure	(c) Third measure
32.11	Augmentation index (Aix)	(<input type="text"/>) <input type="text"/> <input type="text"/> %	(<input type="text"/>) <input type="text"/> <input type="text"/> %	(<input type="text"/>) <input type="text"/> <input type="text"/> %
32.12	Central SBP	<input type="text"/> <input type="text"/> <input type="text"/> [mmHg]	<input type="text"/> <input type="text"/> <input type="text"/> [mmHg]	<input type="text"/> <input type="text"/> <input type="text"/> [mmHg]
32.13	Central DBP	<input type="text"/> <input type="text"/> <input type="text"/> [mmHg]	<input type="text"/> <input type="text"/> <input type="text"/> [mmHg]	<input type="text"/> <input type="text"/> <input type="text"/> [mmHg]
32.14	Heart rate	<input type="text"/> <input type="text"/> <input type="text"/> [bpm]	<input type="text"/> <input type="text"/> <input type="text"/> [bpm]	<input type="text"/> <input type="text"/> <input type="text"/> [bpm]

Section G: TANITA measures

37.1 Height <input type="text"/> <input type="text"/> <input type="text"/> cm	37.2 Weight <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> kg
37.3 BMI <input type="text"/> <input type="text"/> . <input type="text"/>	37.4 BMR <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> kJ
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Kcal	

<p>37.5 Total Body Fat</p> <p>i. Fat Percentage <input type="text"/><input type="text"/> . <input type="text"/><input type="text"/> %</p> <p>ii. Fat mass <input type="text"/><input type="text"/> . <input type="text"/><input type="text"/> Kg</p> <p>iii. Fat free mass <input type="text"/><input type="text"/> . <input type="text"/><input type="text"/> Kg</p> <p>iv. Total body water <input type="text"/><input type="text"/> . <input type="text"/><input type="text"/> Kg</p>	<p>37.6 Impedance</p> <p>i. Whole body <input type="text"/><input type="text"/><input type="text"/> Ω</p> <p>ii. Right leg <input type="text"/><input type="text"/><input type="text"/> Ω</p> <p>iii. Left leg <input type="text"/><input type="text"/><input type="text"/> Ω</p> <p>iv. Right arm <input type="text"/><input type="text"/><input type="text"/> Ω</p> <p>v. Left arm <input type="text"/><input type="text"/><input type="text"/> Ω</p>
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Segmental Analysis

<p align="center">37.7 Right Leg</p> <p>i. Fat Percentage <input type="text"/><input type="text"/> . <input type="text"/><input type="text"/> %</p> <p>ii. Fat mass - <input type="text"/><input type="text"/> . <input type="text"/><input type="text"/> Kg</p> <p>iii. Fat free mass <input type="text"/><input type="text"/> . <input type="text"/><input type="text"/> Kg</p> <p>iv. Pred.muscle mass <input type="text"/><input type="text"/> . <input type="text"/><input type="text"/> Kg</p>	<p align="center">37.8 Left Leg</p> <p>i. Fat Percentage <input type="text"/><input type="text"/> . <input type="text"/><input type="text"/> %</p> <p>ii. Fat mass - <input type="text"/><input type="text"/> . <input type="text"/><input type="text"/> Kg</p> <p>iii. Fat free mass <input type="text"/><input type="text"/> . <input type="text"/><input type="text"/> Kg</p> <p>iv. Pred.muscle mass <input type="text"/><input type="text"/> . <input type="text"/><input type="text"/> Kg</p>
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<p align="center">37.9 Right Arm</p> <p>i. Fat Percentage <input type="text"/><input type="text"/> . <input type="text"/><input type="text"/> %</p> <p>ii. Fat mass - <input type="text"/><input type="text"/> . <input type="text"/><input type="text"/> Kg</p> <p>iii. Fat free mass <input type="text"/><input type="text"/> . <input type="text"/><input type="text"/> Kg</p> <p>iv. Pred.muscle mass <input type="text"/><input type="text"/> . <input type="text"/><input type="text"/> Kg</p>	<p align="center">37.10 Left Arm</p> <p>i. Fat Percentage <input type="text"/><input type="text"/> . <input type="text"/><input type="text"/> %</p> <p>ii. Fat mass - <input type="text"/><input type="text"/> . <input type="text"/><input type="text"/> Kg</p> <p>iii. Fat free mass <input type="text"/><input type="text"/> . <input type="text"/><input type="text"/> Kg</p> <p>iv. Pred.muscle mass <input type="text"/><input type="text"/> . <input type="text"/><input type="text"/> Kg</p>
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<p align="center">37.11 Trunk</p> <p>i. Fat Percentage <input type="text"/><input type="text"/> . <input type="text"/><input type="text"/> %</p> <p>ii. Fat mass - <input type="text"/><input type="text"/> . <input type="text"/><input type="text"/> Kg</p>	<p>iii. Fat free mass <input type="text"/><input type="text"/> . <input type="text"/><input type="text"/> Kg</p> <p>iv. Pred.muscle mass <input type="text"/><input type="text"/> . <input type="text"/><input type="text"/> Kg</p>
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Section H: For Married Children

38.1 How many years have you been married now?

38.2 Name of spouse - _____

38.3 Age of spouse -

38.4 Current address - _____

38.5 How many children do you have?

38.6 Please enter the details of all children in the table below:

(a) Birth order	(b) First name	(c) Date of birth	(d) Gender	(e) Age	(f) Birth weight	(g)Nutrition supplementation recd. Yes=1 and No=2	(h)Age at supplementati on.	Status *

*** Status:**

1. Alive and resident in same village
2. Alive and moved to Hyderabad
3. Alive and moved relatively short distance (within 50 kms of Hyderabad, but not to Hyderabad).
4. Alive and moved relatively long distance (i.e. greater than 50 kms from Hyderabad).
5. Died
6. Any other, specify in comments.

