PID: ☐☐☐☐☐☐☐☐☐ Visit Date: ☐☐ dd ☐☐☐ MMM ☐☐ yy

Visit: ☐☐☐☐

DEMOGRAPHICS

---

1. What is your date of birth? ☐☐ dd ☐☐☐ MMM ☐☐ yy ***OR*** ☐ Don't know

   1.1. About how old are you? (**ONLY** If date of birth unknown) ☐☐ ☐ years ☐ months ☐ weeks ☐ days

2. Are you male or female? ☐ male ☐ female ☐ other ☐ refused

3. What is your country of birth? _____ ***OR*** ☐ Don't know

4. What is your native language? _____ ***OR*** ☐ Don't know

5. What is your ethnic or tribal affiliation? _____ ***OR*** ☐ Don't know

The following questions relate to your father:

6. What is your father's country of birth? _____ ***OR*** ☐ Don't know

7. What is your father's native language? _____ ***OR*** ☐ Don't know

8. What is your father's ethnic or tribal affiliation? _____ ***OR*** ☐ Don't know

The following questions relate to your mother:

9. What is your mother's country of birth? _____ ***OR*** ☐ Don't know

10. What is your mother's native language? _____ ***OR*** ☐ Don't know

11. What is your mother's ethnic or tribal affiliation? _____ ***OR*** ☐ Don't know

PID: ☐☐☐☐☐☐☐☐☐ Visit Date: ☐☐ ☐☐☐ ☐☐
dd MMM yy

Visit: ☐☐☐☐

SMOKING STATUS

1. Have you ever smoked at least 100 cigarettes in your entire life?
   ☐ Yes ☐ No ☐ Don't know
   → ***Skip to Item 8.***

2. How old were you when you first started smoking cigarettes?
   ☐☐ years ***OR*** ☐ Don't know

3. What type of smoker would you currently say you are?
   ☐ An EVERY day smoker
   ☐ A FAIRLY REGULAR (some days) smoker
   ☐ A FORMER smoker
   ☐ Don't know
   ☐ Refused

4. Have you <u>EVER</u> smoked cigarettes <u>EVERY DAY</u> for at least 6 months?
   ☐ Yes ☐ No ☐ Don't know

5. On the days that you smoke, on average, how many cigarettes do you smoke?
   <u>OR</u>
   If you are a former smoker, on the days that you smoked, on average, how many cigarettes did you smoke?
   ☐☐ cigarettes ***OR*** ☐ Don't know

6. Over the past 30 days, on how many days did you smoke?
   <u>OR</u>
   If you are a former smoker, on average, on how many days did you smoke in a month?
   ☐☐ days ***OR*** ☐ Don't know

7. (**<u>ONLY</u>** Former smokers) About how long has it been since you completely quit smoking cigarettes?
   ☐☐ ☐ years ***OR*** ☐ Don't know
   ☐ months
   ☐ weeks
   ☐ days

Date Completed: ☐☐ ☐☐☐ ☐☐ Staff Initials: ☐☐☐
dd MMM yy

PID: | | | | | | | | | |

Visit: | | | | |

SMOKING STATUS

TOBACCO (NON-CIGARETTE) - PRODUCT USE

8. In your lifetime, have you….

8.1.	Smoked at least 50 cigars?	☐ Yes	☐ No	☐ Don't know	☐ Refused
8.2.	Smoked a pipe at least 50 times?	☐ Yes	☐ No	☐ Don't know	☐ Refused
8.3.	Used snuff (such as Skoal, Skoal Bandit or Copenhagen) at least 20 times?	☐ Yes	☐ No	☐ Don't know	☐ Refused
8.4.	Used chewing tobacco (such as Redman, Levi Garrett or Beechnut) at least 20 times?	☐ Yes	☐ No	☐ Don't know	☐ Refused

PID: | | | | | | | | | | Visit Date: | | | | | | | | |
dd MMM yy

Visit: | | | |

ALCOHOL CONSUMPTION

Count as a drink a can or bottle of beer; a wine cooler or a glass of wine; champagne or sherry; a shot of liquor or a mixed drink or cocktail.

1. In your entire life, have you had at least 1 drink of any kind of alcohol? (**NOT** counting small tastes or sips.)
   ☐ Yes ☐ No → ***Skip to end of form.***

2. About how old were you when you first started drinking? (**NOT** counting small tastes or sips.)
   | | years ***OR*** ☐ Don't know

3. During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage?
   | | days ***OR*** ☐ Don't know
   Enter '00' if you did not drink in the past 30 days

4. On the days that you drank during the past 30 days, how many drinks did you usually have each day?
   | | drinks ***OR*** ☐ Don't know
   Enter '00' if you did not drink in the past 30 days.

5. What was the LARGEST number of drinks that you ever drank in a single day?
   | | drinks ***OR*** ☐ Don't know

Date Completed: | | | | | | | | | Staff Initials: | | |
dd MMM yy

PID: ☐☐☐☐☐☐☐☐☐ Visit Date: ☐☐ ☐☐☐ ☐☐
dd MMM yy

Visit: ☐☐☐☐

DRUG USE

In the last 30 days, have you ever used any of the following substances…

		No	Don't know	Yes	Age of first use	# Days Used (in past 30 days)
1.	Sedatives?	☐	☐	☐ →	☐☐ →	☐☐
2.	Tranquilizers?	☐	☐	☐ →	☐☐ →	☐☐
3.	Painkillers?	☐	☐	☐ →	☐☐ →	☐☐
4.	Stimulants?	☐	☐	☐ →	☐☐ →	☐☐
5.	Marijuana, hash, HC, or grass?	☐	☐	☐ →	☐☐ →	☐☐
6.	Cocaine?	☐	☐	☐ →	☐☐ →	☐☐
7.	Crack cocaine?	☐	☐	☐ →	☐☐ →	☐☐
8.	Hallucinogens e.g. LSD?	☐	☐	☐ →	☐☐ →	☐☐
9.	Inhalents or solvents?	☐	☐	☐ →	☐☐ →	☐☐
10.	Heroin?	☐	☐	☐ →	☐☐ →	☐☐
11.	Methamphetamines?	☐	☐	☐ →	☐☐ →	☐☐
12.	Any other non-prescribed medications / substances?	☐	☐	☐ →	☐☐ →	☐☐

12.1. Specify other: _____

Date Completed: ☐☐ ☐☐☐ ☐☐ Staff Initials: ☐☐☐
dd MMM yy

PID: ☐☐☐☐☐☐☐☐☐ Visit Date: ☐☐ dd ☐☐☐ MMM ☐☐ yy

Visit: ☐☐☐☐

ANTHROPOMETRICS

HEIGHT — *wherever possible direct measurements should be used*

1. Height measurements:
   #1 ☐☐☐ cm
   #2 ☐☐☐ cm
   #3 ☐☐☐ cm

   1.1. How tall are you? (**ONLY** If measuring was not possible) ☐☐☐ cm ***Mark N/A if height measurements taken.***

WEIGHT — *wherever possible direct measurements should be used*

2. Weight measurements:
   #1 ☐☐☐ kg
   #2 ☐☐☐ kg
   #3 ☐☐☐ kg

3. Is the participant wearing a cast or medical prosthesis? ☐ Yes ☐ No → ***Skip to Item 8.***

   3.1. If Yes, specify location of cast or medical prosthesis: _____

4. Is the participant wearing street clothes during the weight measurements? ☐ Yes ☐ No

5. How heavy are you? (**ONLY** If measuring was not possible) ☐☐☐ kg ***Mark N/A if weight measurements taken.***

PID: ☐☐☐☐☐☐☐☐☐ Visit Date: ☐☐ ☐☐☐ ☐☐
dd MMM yy

Visit: ☐☐☐☐ **BLOOD PRESSURE**

HIGH BLOOD PRESSSURE

1. Has a healthcare worker ever said that you have high blood pressure or hypertension? ☐ Yes ☐ No ☐ Don't know → **Skip to Item 3.**

   1.1. If yes, then at what age were you first told this? ☐☐ years ***OR*** ☐ Do

   1.2. ***FOR WOMEN:*** Was this during pregnancy only? ☐ Yes ☐ No

2. Have you ever taken medication for hypertension / high blood pressure? ☐ Yes now ☐ Yes not now ☐ No ☐ Don't know

   Skip to Item 3. (No / Don't know)

   2.1. If yes, then at what age did you begin taking medicine for this? ☐☐ years ***OR*** ☐ Don't know

BLOOD PRESSURE READINGS

3. Date BP measurements taken: ☐☐ ☐☐☐ ☐☐
dd MMM yy

   3.1. For blood pressure measurements, specify Aneroid sphygmomanometers name and model: _____

   3.2. Blood pressure cuffs sizes (S, M, L, XL): ☐ S ☐ M ☐ L ☐ XL

	Systolic	**Diastolic**
3.3. Blood pressure measurement #1:	☐☐☐ /	☐☐☐
3.4. Blood pressure measurement #2:	☐☐☐ /	☐☐☐
3.5. Blood pressure measurement #3:	☐☐☐ /	☐☐☐

Date Completed: ☐☐ ☐☐☐ ☐☐ Staff Initials: ☐☐☐
dd MMM yy

PID: | | | | | | | | | |

Visit: | | | | |

URINE TEST RESULTS

1. Sample collection date: | | | | | | | | | dd MMM yy

2. Urinary albumin: | | | | | mg/L

3. Urinary creatinine: | | | | | mg/L

4. Urinary total protein: | | | | | mg/L

Date Completed: | | | | | | | | dd MMM yy

Staff Initials: | | |

PID: ☐☐☐☐☐☐☐☐☐   Visit Date: ☐☐ ☐☐☐ ☐☐ (dd MMM yy)

Visit: ☐☐☐☐

KIDNEY DISEASE

PERSONAL HISTORY OF KIDNEY FAILURE

1. Has a doctor or healthcare worker ever told you that you had kidney failure? ☐ Yes ☐ No ☐ Don't know → ***Skip to Item 2.*** (No / Don't know)

   1.1. If Yes, are one or both working well now? ☐ Yes ☐ No ☐ Don't know

   1.2. How old were you when you were first told by a medical person that you had kidney failure? ☐☐ years ***OR*** ☐ Don't know

   1.3. Are you currently on renal dialysis? ☐ Yes ☐ No ☐ Don't know

2. Have you ever had a kidney transplant? ☐ Yes ☐ No ☐ Don't know

3. Has anyone in your family either had kidney disease or died from it? ☐ Yes ☐ No ☐ Don't know → ***Skip to Item 4.*** (No / Don't know)

   3.1. Do you know what type of kidney disease? ☐ Yes ☐ No

   3.2. If Yes, please specify: ______________________

4. Has a doctor ever told you that your kidneys have low function? ☐ Yes ☐ No ☐ Don't know

5. Has a doctor or healthcare worker told you that you have kidney disease? ☐ Yes ☐ No ☐ Don't know

    Date Completed: ☐☐ ☐☐☐ ☐☐ (dd MMM yy)   Staff Initials: ☐☐☐

PID: | | | | | | | | | |

PRESCRIBED MEDICATION

1. Medication: _____ Dosage: ☐ daily ☐ BID ☐ TID ☐ QID ☐ Noct

Strength: | | | | | ☐ mg ☐ ml ☐ tb

Reason: _____

Start date: | | | | | | | | dd MMM yy Stop date: | | | | | | | | dd MMM yy

Staff Initials: _____ Date Completed: _____

2. Medication: _____ Dosage: ☐ daily ☐ BID ☐ TID ☐ QID ☐ Noct

Strength: | | | | | ☐ mg ☐ ml ☐ tb

Reason: _____

Start date: | | | | | | | | dd MMM yy Stop date: | | | | | | | | dd MMM yy

Staff Initials: _____ Date Completed: _____

3. Medication: _____ Dosage: ☐ daily ☐ BID ☐ TID ☐ QID ☐ Noct

Strength: | | | | | ☐ mg ☐ ml ☐ tb

Reason: _____

Start date: | | | | | | | | dd MMM yy Stop date: | | | | | | | | dd MMM yy

Staff Initials: _____ Date Completed: _____

4. Medication: _____ Dosage: ☐ daily ☐ BID ☐ TID ☐ QID ☐ Noct

Strength: | | | | | ☐ mg ☐ ml ☐ tb

Reason: _____

Start date: | | | | | | | | dd MMM yy Stop date: | | | | | | | | dd MMM yy

Staff Initials: _____ Date Completed: _____

PID: ☐☐☐☐☐☐☐☐☐ Visit Date: ☐☐ ☐☐☐ ☐☐
dd MMM yy

Visit: ☐☐☐☐

CARDIO VASCULAR DISEASE

ARRYTHMIA (ATRIAL AND VENTRICULAR)

1. Have you ever been told you have / had a heart rhythm problem called atrial fibrillation? ☐ Yes ☐ No ☐ Don't know → ***Skip to Item 2.***

   1.1. If Yes, provide date of first episode: ☐☐ ☐☐☐ ☐☐ ***OR*** ☐ Don't know
   dd MMM yy

   1.2. Did you go to a hospital / clinic to see a doctor?
   ☐ Yes, I went to hospital / clinic
   ☐ Yes, I saw a doctor
   ☐ No
   ☐ Don't know

2. Have you got a permanent pacemaker inserted? ☐ Yes ☐ No ☐ Don't know

   2.1. If Yes, what year was it inserted? ☐☐☐☐ ***OR*** ☐ Don't know
   yyyy

3. Have you taken or are you taking any of these cardiovascular medications:

   3.1. Anticoagulants (Coumadin; Warfarin; etc.)
   ☐ Yes, now
   ☐ Yes, not now
   ☐ No
   ☐ Don't know

   3.2. Antiarrhythmics (Quinidine; Procainmide; Norpace; Disopyramide; etc.)
   ☐ Yes, now
   ☐ Yes, not now
   ☐ No
   ☐ Don't know

RHEUMATIC FEVER / RHEUMATIC HEART DISEASE

4. Has a doctor ever said you had rheumatic fever (inflammatory rheumatism)? ☐ Yes ☐ No ☐ Don't know → ***Skip to end of form.***

   4.1. If yes, have you had it in the past 12 months? ☐ Yes ☐ No ☐ Don't know

   4.2. Are you taking any medication for it? ☐ Yes ☐ No ☐ Don't know

   4.2.1. If yes, please specify medication: _____

Date Completed: ☐☐ ☐☐☐ ☐☐ Staff Initials: ☐☐☐
dd MMM yy

PID: ☐☐☐☐☐☐☐☐☐ Visit Date: ☐☐ ☐☐☐ ☐☐
dd MMM yy

Visit: ☐☐☐☐

STROKE HISTORY

ISCHEMATIC INFARCTION AND HAEMORRHAGE

1. Were you ever told by a doctor or healthcare worker that you had a stroke? ☐ Yes ☐ No ☐ Don't know

2. Were you ever told by a doctor or healthcare worker you had a TIA, mini-stroke, or transient ischemic attack? ☐ Yes ☐ No ☐ Don't know → ***Skip to Item 3.***

   2.1. If Yes, how long did the weakness last?
   - ☐ A few minutes
   - ☐ Less than 15 minutes
   - ☐ Less than an hour
   - ☐ A few hours
   - ☐ More than a day

3. Have you ever had a sudden painless weakness on one side of your body? ☐ Yes ☐ No ☐ Don't know

4. Have you ever had a sudden numbness or a dead feeling on one side of your body? ☐ Yes ☐ No ☐ Don't know

5. Have you ever had a sudden painless loss of vision in one or both eyes? ☐ Yes ☐ No ☐ Don't know

6. Have you ever suddenly lost one half of your vision? ☐ Yes ☐ No ☐ Don't know

7. Have you ever suddenly lost the ability to understand what people are saying? ☐ Yes ☐ No ☐ Don't know

8. Have you ever suddenly lost the ability to express yourself verbally or in writing? ☐ Yes ☐ No ☐ Don't know

 Date Completed: ☐☐ ☐☐☐ ☐☐ Staff Initials: ☐☐☐
dd MMM yy

PID: ☐☐☐☐☐☐☐☐☐ Visit Date: ☐☐ dd ☐☐☐ MMM ☐☐ yy

Visit: ☐☐☐☐

DIABETES HISTORY

PERSONAL HISTORY OF TYPE 1 AND TYPE 2 DIABETES

1. Has a doctor or healthcare worker ever told you that you have diabetes (sugar in blood)? ☐ Yes ☐ No ☐ Don't know → ***Skip to end of form.***

   1.1. If Yes, what type of diabetes do you have?
   - ☐ Type 1
   - ☐ Type 2
   - ☐ Type 1 and 2
   - ☐ Don't know

   1.2. If Yes, are you taking medication for it? ☐ Yes ☐ No ☐ Don't know → ***Skip to Item 2.***

   1.3. If Yes, are you taking insulin? ☐ Yes ☐ No ☐ Don't know → ***Skip to Item 2.***

      1.3.1. If you are not taking insulin, are you taking other medication? ☐ Yes ☐ No ☐ Don't know

2. At what age was your diabetes first treated? ☐☐ years ***OR*** ☐ Don't know

3. Was insulin your first diabetes medicine? ☐ Yes ☐ No ☐ Don't know

4. ***FOR WOMEN ONLY:*** Did diabetes occur <u>only</u> during pregnancy? ☐ Yes ☐ No ☐ Don't know

PID: ☐☐☐☐☐☐☐☐☐ Visit Date: ☐☐ ☐☐☐ ☐☐
dd MMM yy

Visit: ☐☐☐☐ **SELF REPORT HIV**

SELF-REPORT OF HUMAN IMMUNODIFICIENCY VIRUS (HIV) TESTING

1. Have you ever been tested for HIV? ☐ Yes ☐ No ☐ Don't know ☐ Refused
   → ***Skip to end of form.***

2. When did you have your most recent HIV test? ☐☐ ☐☐☐ ☐☐ ***OR*** ☐ Don't know
   dd MMM yy

3. What was the result of your most recent HIV test?
   - ☐ Positive
   - ☐ Negative
   - ☐ Indeterminate
   - ☐ Never obtained results
   - ☐ Don't know
   - ☐ Refused to answer

4. Are you on HIV treatment? ☐ Yes ☐ No ☐ Don't know ☐ Refused
   → ***Skip to end of form.***

   4.1. If Yes, when did you initiate (start) HIV treatment? ☐☐ ☐☐☐ ☐☐ ***OR*** ☐ Don't know
   dd MMM yy

PID: ☐☐☐☐☐☐☐☐☐ Visit Date: ☐☐ ☐☐☐ ☐☐
dd MMM yy

Visit: ☐☐☐☐

DYSLIPIDEMIA

1. Has a doctor or healthcare worker ever told you that you have dyslipidemia? ☐ Yes ☐ No ☐ Don't know
   → ***Skip to end of form.***

   1.1. If Yes, at what age were you first told this? ☐☐ years ***OR*** ☐ Don't know

   1.2. Was it confirmed by a laboratory test? ☐ Yes ☐ No ☐ Don't know

   1.3. Have you ever taken medication for dyslipidemia?
   ☐ Yes, now
   ☐ Yes, not now
   ☐ No
   ☐ Don't know
   ← ***Skip to end of form.***

   1.3.1. If yes, then at what age did you begin taking medicine for this? ☐☐ years ***OR*** ☐ Don't know

Date Completed: ☐☐ ☐☐☐ ☐☐ Staff Initials: ☐☐☐
dd MMM yy

PID: ☐☐☐☐☐☐☐☐☐ Visit Date: ☐☐ ☐☐☐ ☐☐
dd MMM yy

Visit: ☐☐☐☐ **CANCER**

---

1. Have you ever had cancer? ☐ Yes ☐ No → ***Skip to end of form.***

2. If Yes, please specify cancer type and site: _____

_____

2.1. Date of diagnosis for this cancer: ☐☐ ☐☐☐ ☐☐
dd MMM yy

2.2. Age at diagnosis for this cancer: ☐☐ years ***OR*** ☐ Don't know

2.3. Did you have surgery for this cancer? ☐ Yes ☐ No ☐ Don't know

2.3.1. If yes, name of procedure: _____

2.4. Indicate what treatment/s you had and the dates of treatment completion:

	dd	MMM	yy	
☐ Chemotherapy →	☐☐	☐☐☐	☐☐	***OR*** ☐ Ongoing
☐ Hormonal therapy →	☐☐	☐☐☐	☐☐	***OR*** ☐ Ongoing
☐ Radiotherapy →	☐☐	☐☐☐	☐☐	***OR*** ☐ Ongoing
☐ Other therapy →	☐☐	☐☐☐	☐☐	***OR*** ☐ Ongoing

If other, specify: _____

2.5. Have you had a recurrence of this cancer? ☐ Yes ☐ No ☐ Don't know
→ ***Skip to end of form.***

2.5.1. If yes, date of recurrence: ☐☐ ☐☐☐ ☐☐
dd MMM yy

2.5.2. Where did cancer recur? _____

PID: ☐☐☐☐☐☐☐☐☐ Visit Date: ☐☐ dd ☐☐☐ MMM ☐☐ yy

Visit: ☐☐☐☐

OTHER INFECTIOUS DISEASES

SELF-REPORT OF OTHER INFECTIOUS DISEASE HISTORY

Has a doctor or healthcare worker ever told you that you had any of the following conditions:

1. Tuberculosis? ☐ Yes → ☐☐ Age diagnosed (years)
   ☐ No
   ☐ Don't know
   ☐ Refused

2. Malaria? ☐ Yes → ☐☐ Age diagnosed (years)
   ☐ No
   ☐ Don't know
   ☐ Refused

3. Sleeping sickness? ☐ Yes → ☐☐ Age diagnosed (years)
   ☐ No
   ☐ Don't know
   ☐ Refused

4. Hepatitis A? ☐ Yes → ☐☐ Age diagnosed (years)
   ☐ No
   ☐ Don't know
   ☐ Refused

5. Hepatitis B? ☐ Yes → ☐☐ Age diagnosed (years)
   ☐ No
   ☐ Don't know
   ☐ Refused

6. Hepatitis C? ☐ Yes → ☐☐ Age diagnosed (years)
   ☐ No
   ☐ Don't know
   ☐ Refused

Date Completed: ☐☐ dd ☐☐☐ MMM ☐☐ yy Staff Initials: ☐☐☐