Precision Medicine Diabetes And Hypertension Study

Record ID _____

Record ID _____

A. General Information

	Yes	No
Has consent been granted?	◯	◯

Participating hospital _____

Date of interview _____

B. Demographic Information

Surname and Name of participant _____
(please make sure that you start with the surname of the participant)

Gender
◯ Male
◯ Female

Date of Birth _____
(DD/MM/YYYY)

Address of participant _____

Landline/ cellphone number _____
(If the patient doesn't know enter 777)

	Donor (Patient)	Father	Mother
Xhosa	☐	☐	☐
Zulu	☐	☐	☐
Admixed	☐	☐	☐
Other	☐	☐	☐

If other, please specify _____

Religion
◯ African traditional
◯ Christianity
◯ Islam
◯ Judaism

If other, please specify _____

In which region of East London do you live?
◯ Urban
◯ Rural

What is your home language?

- ◯ Afrikaans
- ◯ English
- ◯ IsiZulu
- ◯ IsiXhosa
- ◯ Other

If other, please specify _____

C. Socioeconomic Profile

Employment status

- ◯ Employed
- ◯ Unemployed
- ◯ Social grant recipient
- ◯ Student

	Never went to school	Primary School	High School	Degree/ Diploma
What is the highest level of education that you have achieved?	◯	◯	◯	◯

What is your average monthly household income?

- ☐ No income
- ☐ R100-R1 500
- ☐ R1 600-R3 000
- ☐ R3 100-R9 000
- ☐ >R10 000
- ☐ >R20 000

Does your household have any of the following items?

- ☐ A television
- ☐ A radio
- ☐ A landline telephone
- ☐ A desktop computer/ laptop
- ☐ A refrigerator
- ☐ A vacuum cleaner
- ☐ A microwave oven
- ☐ An electric or a gas stove
- ☐ A washing machine
- ☐ Electricity that is connected to the main?

What type of housing do you live in?

- ◯ Built formal unit/private owned
- ◯ Council/core house
- ◯ Informal settlement/shelter/ shack /hostel/other

D. Anthropometric Measurements

Weight (Kg) _____

Height (cm) _____

Body Mass Index _____

Waist circumference (cm) _____

Hip circumference (cm) _____

Mid-upper arm circumference (cm) _____

Self-assessment of obesity

- ◯ Normal Weight
- ◯ Average
- ◯ Overweight

E. Behavior Management

	Yes	No	Never
Do you smoke tobacco products? If yes, are you a current smoker?	◯	◯	◯
If you are a current smoker, do you smoke daily?	◯	◯	◯
If former smoker, did you smoke daily?	◯	◯	◯

How many cigarettes or pipes do/did you smoke per day?

- ◯ 1-9
- ◯ 10-19
- ◯ >20

How old were you when you started smoking?

_____

(If the patient doesn't remember enter 777)

If not a current smoker, when did you quit?

_____

(If the patient doesn't remember enter 777)

Do you have a household member who smokes?

- ◯ Yes
- ◯ No

	Yes	No
Do you currently use smokeless tobacco such as snuff or chewing tobacco?	☐	☐
Do you currently use smokeless tobacco daily?	☐	☐
If no, did you use any of the mentioned products in the past?	☐	☐

Do you consume alcohol?

- ◯ Current drinker
- ◯ Quit drinking
- ◯ Never drank
- ◯ Occasional drinker

If current drinker, how often do you consume alcohol?

- ☐ Occasionally
- ☐ Moderate
- ☐ Males excessive drinking (> 3 units/day) or (21units/week)
- ☐ Females excessive drinking (> 2 units/day) or (14 units/week)

If you quit alcohol, did you have a drink in the past month?

- ◯ Yes
- ◯ No

F. Dietary History

How many times a week do you consume fruits and/or vegetables

- ◯ One to three times a day
- ◯ More than three times a day
- ◯ Never

What type of oil or fat is commonly used in your household?

- ◯ Vegetable oil
- ◯ Butter
- ◯ Margarine
- ◯ Other
- ◯ Don't know

If other, please specify

_____

How often do you eat fast food?

- ◯ Every day
- ◯ A few times a week
- ◯ A few times a month
- ◯ Less than a few times a month
- ◯ Never

Salt intake

- ◯ Do you add extra salt to your food?
- ◯ Moderate salt intake?
- ◯ No salt intake

G. Physical Activity

Do you exercise?

- ◯ Vigorously
- ◯ Moderately
- ◯ Sometimes
- ◯ Never
- ◯ If no, do you at least do any activity vigorously for 10 min?

Does your work involve intense physical activity for at least 30 min continuously, for at least 5 times a week?

- ◯ Yes
- ◯ No

What type of physical activity do you engage in while traveling to and from work?

- ◯ Walking or cycling (1-29 min)
- ◯ Walking or cycling for (> 30 min)
- ◯ Car
- ◯ Public transport and walking (1-29 min)
- ◯ Other

In a 24 hr day, how much time do you spend sitting (at a desk, traveling or in front of a TV)

_____

H. Medical History

Which condition are you currently taking Medication for?

- ☐ Diabetes
- ☐ Hypertenison
- ☐ Both

If you are diabetic, what type of diabetes have you been diagnosed with?

- ☐ Type 1
- ☐ Type 2
- ☐ Gestational diabetes
- ☐ N/A

Do you suffer from any of the following conditions?

- ☐ Neuropathy
- ☐ Retinopathy
- ☐ Stroke
- ☐ Depression
- ☐ Renal failure
- ☐ Heart failure
- ☐ Stomach ulcers
- ☐ Other

(If other, please specify)

If other, please specify _____

	Yes	No
Have you ever been told by a doctor or nurse to: Control your blood sugar	○	○
Control your pressure	○	○

	< 5 yrs	>5 yrs	Don't know
How long have you been diagnosed with diabetes?	○	○	○
How long have you been diagnosed with hypertension?	○	○	○

What medication are you currently using?

- ☐ Insulin
- ☐ Metformin
- ☐ Glibenclamide
- ☐ Gliclazide
- ☐ Aspirin
- ☐ Simvastatin
- ☐ Amlodipine
- ☐ Hydrochlorothiazide
- ☐ Herbal medication (Specify under other)
- ☐ HIV medication (Specify under other)
- ☐ Amitriptylin
- ☐ Tramodol
- ☐ Lansoprazole
- ☐ Omeprazole
- ☐ Octraphane
- ☐ Lactucose
- ☐ Carvedilol
- ☐ Spiranalatone
- ☐ Enalapril
- ☐ Glunipidine
- ☐ Furosemide
- ☐ Thyroxime
- ☐ Sitagliptin
- ☐ Linalogliptin
- ☐ Alanogliptin
- ☐ paracetamol
- ☐ Bromocriptin
- ☐ Pramlintide

If other, please specify _____

If other, please specify

_____

	Yes	No	Don't know
Is your diabetes under control?	◯	◯	◯
Is your blood pressure under control?	◯	◯	◯

I. Self-Care Behaviour

	Yes	No
Home glucose monitoring	◯	◯
Home blood pressure monitoring	◯	◯
Adherence to medication	◯	◯
Adherence to exercise	◯	◯
Adherence to clinical appointment	◯	◯

	Cannot achieve	Moderate control	Highly certain to achieve control
Are you able to achieve control of your blood sugar?	◯	◯	◯
Are you able to achieve control over your blood pressure?	◯	◯	◯

I feel confident

◯ Following dietary adjustments
◯ Using medication correctly
◯ Exercise regularly ◯ Stopped cigarette smoking ◯ Reduced alcohol intake
◯ Meeting treatment targets
◯ Other

J. Family Medical History

	Y es	No	Don't know
Do you have a blood relative with a history of diabetes?	☐	☐	☐

If yes, please select the person with diabetes in your family

☐ Mother
☐ Father
☐ Sibling
☐ Aunt/uncle
☐ Child
☐ Maternal grandparents
☐ Paternal grandparents

If yes, what type of diabetes? ◯ Type 1 ◯ Type 2 ◯ I don't know

	Yes	No	Don't know	N/A
Do you have a blood relative who is/was suffering from hypertension?	◯	◯	◯	◯

If yes, please select the person with diabetes in your family

- ☐ Mother
- ☐ Father
- ☐ Sibling
- ☐ Aunt/uncle
- ☐ Child
- ☐ Maternal grandparents
- ☐ Paternal grandparents

Did you take hypertension medication this morning?

- ◯ Yes
- ◯ No

Name of medication taken _____

Time taken _____

Dosage (mg) _____

Record all drugs brought in by the respondent

_____

(The interviewer should make sure that they record all medication brought by the corespondent)

How many medications do you use regularly or daily

_____

(Record the number of medicines)

L. Clinical Visit 1

Most recent Hba1c readings _____

Fasting blood sugar readings _____

Postpradial blood sugar readings _____

Systolic mmHg Reading 1 _____

Diastolic mmHg reading 1 _____

Heart rate reading 1 _____

Proteinuria (using urine dipstick)

- ◯ Yes
- ◯ No

Total Cholesterol (mmol/L) _____

HDL-cholesterol (mmol/L) _____

LDL-Cholesterol _____

Triglycerides (mmol/L) _____

	Yes	No
Do you take all your prescribed diabetes medication?	◯	◯
Do you take all your prescribed hypertension medication?	◯	◯

If you don't take your medication regularly, what is the reason for not taking your medication as directed?

- ☐ I can't afford the cost
- ☐ Medication easily easly available
- ☐ I don't like taking medication
- ☐ I don't like the side effects
- ☐ I prefer alternative medication
- ☐ I sometimes forget
- ☐ The clinic is too far
- ☐ The queue at the clinic is too long
- ☐ There are no doctors at the clinic

If other, specify

_____

M. Clinical Visit 2

Most recent Hba1c reading _____

Fasting blood sugar reading _____

Postprandial blood sugar reading _____

Systolic mmHg reading 1 _____

Diastolic reading 1 _____

Heart rate reading 1 _____

Proteinuria (using deep stick results)

- ◯ Yes
- ◯ No

	Total cholesterol (mmol/l)	HDL cholesterol (mmol/l)	LDL cholesterol (mmol/l)	Triglycerides (mmol/l)
Lipid profile (most recent)	☐	☐	☐	☐

Total Cholesterol (mmol/L) _____

LDL-Cholesterol (mmol/L) _____

HDL-Cholesterol (mmol/L) _____

Triglycerides (mmo/L) _____

	Yes	No
Do you take all your prescribed diabetes medication	◯	◯
Do you take all your prescribed hypertension medication	◯	◯

If you don't take your medication regularly, what is the reason for not taking your medication as directed?

- ☐ I can't afford the cost
- ☐ Medication easily available
- ☐ I don't like taking medication
- ☐ I don't like the side effects
- ☐ I prefer alternative medication
- ☐ I sometimes forget
- ☐ The clinic is too far
- ☐ The queue at the clinic is too long
- ☐ There are no doctors at the clinic

If other Please specify _____

N.Clinical Visit 3

Most recent Hba1c reading _____

Fasting blood sugar reading _____

Postprandial blood sugar reading _____

Blood pressure readings: Systolic mmHg reading 1 _____

Diastolic mmHg reading _____

Heart rate reading 1 _____

Proteinuria (using a urine dipstick)

- ◯ Yes
- ◯ No

Total Cholesterol (mmol/L) _____

HDL-Cholesterol (mmol/L) _____

LDL-Cholesterol (mmol/L) _____

Triglycerides (mmo/L) _____

Creatinine _____

GFR _____

	Yes	No
Do you take all your prescribed diabetes medication?	◯	◯
Do you take all your prescribed hypertension medication?	◯	◯

If you don't take your medication regularly, what is the reason for not taking your medication as directed?

- ☐ I can't afford the cost
- ☐ Medication easily easly available
- ☐ I don't like taking medication
- ☐ I don't like the side effects
- ☐ I prefer alternative medication
- ☐ I sometimes forget
- ☐ The clinic is too far
- ☐ The queue at the clinic is too long
- ☐ There are no doctors at the clinic

If other, please specify

_____