PATIENT CODE:	

Part-I (Background Information)

1	Block Code	2	Village	3	Type of Facility: [_]0 Public [_]1 Private	4	Serial Number

5	Age in Years	
6	Sex	[_]0 Female [_]1 Male
7	Religion	[_]0 Hindu [_]1 Islam [_]2 Christian [_]3 Others
8	Marital Status	[_]0 Never Married [_]1 Currently Married [_]2 Separated/Divorcee [_]3 Widow/Widower
9	Date of Birth (If available)	
11	Ethnicity	[_]0 Schedule cast [_]1 Schedule Tribe [_]2 General
12	Present place of living	[_]0 Urban [_]1 Semi urban [_]2 Rural
13	Highest Education	[ ]0 Illiterate [ ]1 Primary [ ]2 High school or Secondary [ ]3 Graduation and above
14	Housing type:	[_]0 Kutcha [_]1 Pucca [_]2 Semi Pucca
15	Gross family income per month(INR):	
16	APL/BPL (as per ration card):	[_]0 APL [_]1 BPL
17	In the **past 12 months** have you been **admitted** to hospital for any diseases (Excluding trauma/accident)?	[_]0 No [_]1 Yes [_]2 Don't Remember
18	If ***Yes***, how many nights altogether have you stayed in hospital as a patient in the past 12 months	..... (Nights)
19	***Besides the hospitalization***, in past 12 months how many times you have visited a ***Public Hospital*** for consultation?	..... times
20	***Besides the hospitalization***, in past 12 months how many times you have visited a ***Private Hospital*** for consultation?	..... times
21	How many *different types* of medicines/drugs are you taking at present?	..... (count)
22	Are you covered under any health insurance? Like Rastriya Swasthya Bima Yojana/Employee State Insurance Scheme	[_]0 No [_]1Yes [_]2 Don't know

PATIENT CODE:

Instruction: *Please ask both **'A' & 'B'** sections for each disease (Where ever applicable), if the **answer for either 'A' or 'B'** is **'Yes'** then **pick the sheets** asking generic questions about the same **disease.***

23. Conditions		Yes/ No
Arthritis	A. Have you ever been **diagnosed** by a doctor with ***Arthritis?***	Yes[_] No[_]
	B. In the **last 12 months** have you experienced ***pain, aching, stiffness or swelling in or around the joints (like arms, hands, legs or feet)*** which were not related to an injury and lasted for more than a month?	Yes[_] No[_]
Diabetes	A. Have you ever been **diagnosed** with ***Diabetes*** (high blood sugar)? *(Not including diabetes associated with a pregnancy)*	Yes[_] No[_]
	B. Not applicable	NA
Hypertension	A. Have you ever been **diagnosed** with ***high blood pressure*** (Hypertension)?	Yes[_] No[_]
	B. *Not applicable*	NA
Chronic Lung Diseases(Including Asthma)	**A.** Have you ever been **diagnosed** with ***Chronic Lung Disease (Emphysema, Bronchitis, Asthma, COPD)?***	Yes[_] No[_]
	B. *Not applicable*	NA
Acid Peptic Disease	A. Have you been **diagnosed** with ***Acid-Peptic Ulcer Disease*** (Gastritis) in **last 12 months??**	Yes[_] No[_]
	B. *Not applicable*	NA
Chronic Back Ache	A. In **last 12 months,** have you been diagnosed with ***Chronic Back Pain***?	Yes[_] No[_]
	B. In **last 12 months,** have you had continuous Back pain for more than 3 weeks?	Yes[_] No[_]
Heart disease	A. Have you ever been **diagnosed** with ***Angina/ heart attack/heart disease?***	Yes[_] No[_]
	B. In the **last 12 months** have you experienced ***any pain or discomfort*** in your chest when you walk uphill or hurry or normal walking?	Yes[_] No[_]
Stroke	A. Have you ever **been told** by a health professional that you have had a ***Stroke***?	Yes[_] No[_]
	B. In the **last 12 months** have you suffered from **sudden onset of paralysis or weakness** in your arms or legs on one side of your body for **more than 24 hours?**	Yes[_] No[_]
Blindness	A. Have you been diagnosed with **blindness**?	Yes[_] No[_]
	B. Do you have ***difficulty with vision*** (Answer **No** if you can see **OK** with **glasses**)?	Yes[_] No[_]
Deafness	A. In the **last 12 months**, have you been diagnosed with **deafness**?	Yes[_] No[_]
	B. In the **last 12 months** do you have ***Deafness or difficulty in hearing*** for **more than 3 months?**	Yes[_] No[_]
Dementia	A. Have you ever been **diagnosed** with D***ementia***?	Yes[_] No[_]
	B. Do you have ***memory problem*** which **hinders** your ***Activities in Daily Life***?	Yes[_] No[_]
Alcohol disorder	A. Have you **visited** any doctor because of ***Alcohol Habit***?	Yes[_] No[_]
	B. Are you ***habituated to Alcohol***?	Yes[_] No[_]
Cancer	A. Have you ever been **diagnosed** with any type of ***Cancer***?	Yes[_] No[_]
	B. *Not applicable*	NA
Chronic Kidney Diseases	A. Have you ever been **diagnosed** with a ***long term Kidney problem***?	Yes[_] No[_]
	B. Have you ever been on ***Dialysis***?	Yes[_] No[_]
Epilepsy	A. Have you ever **been told** by a health professional that you have ***Epilepsy***?	Yes[_] No[_]
	B. Have you ever **suffered** from ***sudden onset of seizure*** *while at work or at rest*?	Yes[_] No[_]
Thyroid Disease	A. Have you ever been **diagnosed** with ***Thyroid diseases***?	Yes[_] No[_]
	B. *Not applicable*	NA
Tuberculosis	A. Do you suffer from ***TB***?	Yes[_] No[_]
	B. Are you **under** any **treatment for *TB***?	Yes[_] No[_]
Filariasis	A. Do you have ***Filaria*?**	Yes[_] No[_]
	B. *Not applicable*	

PATIENT CODE:

24	**DEPRESSION**				
	Over the past 2 weeks, how often have you been bothered by any of the following problems:	Not at all	Several Days	More than half of the days	Nearly every Day
A	Little interest or pleasure in doing things	0	1	2	3
B	Feeling down, depressed, or hopeless.	0	1	2	3
If a + b = 2 or more, continue to c. If not, then move to next condition					
C	Trouble falling/staying asleep, sleeping too much.	0	1	2	3
D	Feeling tired or having little energy.	0	1	2	3
E	Poor appetite or overeating.	0	1	2	3
F	Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
G	Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
H	Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
I	Thoughts that you would be better off dead or of hurting yourself in some way.	0	1	2	3
C.	Have you ever been to **private health center** for feeling sad/ depressed? (e.g. Clinic, hospital)			[ ] Yes	[ ] No
D.	Have you ever been to **government hospital** for feeling sad/ depressed?			[ ] Yes	[ ] No
*If **Yes** to C or D, then **Ask** E., If **No**, **move** to G*					
E	When did you **last visit** a doctor about feeling sad/ depressed? *Enter number of months(M) or years (Y) or Today (T)*			.....M T .....Y	
F	Where did you **last visit** for this condition? 1. PHC[ ] 2.CHC [ ] 3.SDH [ ] 4.DH [ ] 5.MCH [ ] 6. Private [ ]				
G	Have you ever been prescribed any **medication** for feeling sad/ depressed?			[ ] Yes [ ] No [ ]NA	
	If yes, continue to H. If no, go to J				
H	If **yes**, are you still **continuing** it?			[ ] Yes [ ] No [ ] NA	
I	If **No**, what was the reason for **stopping** it?				
J	Are you taking any medication for sadness/depression that wasn't prescribed by a doctor or nurse (e.g. you bought it at a pharmacy or given to you by a relative)?			[ ] Yes [ ] No	
K	Have you ever consulted **any other treatment** such as Ayuraveda/ Traditional Healer/ Faith Healer etc for feeling sad/depressed ?				
L	How much is depression **limiting your activities**? 1. Not at all [ ] 2.A little[ ] 3.Somewhat [ ] 4. Quite a bit [ ] 5. A lot[ ]				

PATIENT CODE:

25. Have you been diagnosed with depression by any physician? [_] Yes [_] No

26. Do you suffer from any other chronic health problems? [_] Yes [_] No

If yes, name them and indicate how much each problem is limiting you in your daily activities

1..... 1. Not at all [_] 2.A little[_] 3.Somewhat [_] 4. Quite a bit [_] 5. A lot[_]

2..... 1. Not at all [_] 2.A little[_] 3.Somewhat [_] 4. Quite a bit [_] 5. A lot[_]

3.....1. Not at all [_] 2.A little[_] 3.Somewhat [_] 4. Quite a bit [_] 5. A lot[_]

PATIENT CODE:	

SF-12v2™ Health Survey Scoring Demonstration

This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities.

Answer every question by selecting the answer as indicated. If you are unsure about how to answer a question, please give the best answer you can.

1. In general, would you say your health is:
   [ ]Excellent [ ] Very good [ ] Good [ ] Fair [ ] Poor

2. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
A. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling	[ ]	[ ]	[ ]
B. Climbing several flights of stairs	[ ]	[ ]	[ ]

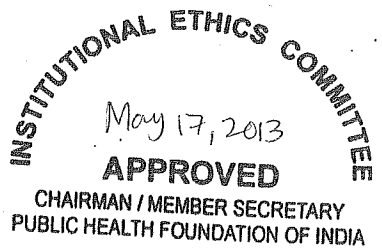
3. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
A. Accomplished less than you would like	[ ]	[ ]	[ ]	[ ]	[ ]
B. Were limited in the kind of work or other activities	[ ]	[ ]	[ ]	[ ]	[ ]

4. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
A. Accomplished less than you would like	[ ]	[ ]	[ ]	[ ]	[ ]
B. Did work or activities less carefully than usual	[ ]	[ ]	[ ]	[ ]	[ ]

5. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?



[ ] Not at all [ ] A little bit [ ] Moderately [ ] Quite a bit [ ] Extremely

6. **These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.**

How much of the time during the past 4 weeks...

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
A. Have you felt calm and peaceful?	[ ]	[ ]	[ ]	[ ]	[ ]
B. Did you have a lot of energy?	[ ]	[ ]	[ ]	[ ]	[ ]
C. Have you felt downhearted and depressed?	[ ]	[ ]	[ ]	[ ]	[ ]

7. **During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?**

All of the time	Most of the time	Some of the time	A little of the time	None of the time
[ ]	[ ]	[ ]	[ ]	[ ]

Thank you for completing these questions!

PATIENT CODE:

Disease name:

Arthritis	[ ]	Heart disease	[ ]	Cancer	[ ]
Diabetes	[ ]	Stroke	[ ]	Chronic kidney disease	[ ]
Hypertension	[ ]	Blindness	[ ]	Epilepsy	[ ]
Chronic lung disease	[ ]	Deafness	[ ]	Thyroid	[ ]
Acid Peptic disease	[ ]	Dementia	[ ]	Tuberculosis	[ ]
Chronic back ache	[ ]	Alcohol	[ ]	Filaria	[ ]

C.	Have you ever been to **private health center** for this condition? (e.g. Clinic, hospital)	[_] Yes [_] No
D.	Have you ever been to **government hospital** for this condition?	[_] Yes [_] No
*If **Yes** to C or D, then **Ask** E., If **No**, move to G*		
E	When did you **last visit** a physician about this disease? *Enter number of months(M) or years (Y) or Today (T)*	.....M T .....Y
F	Where did you **last visit** for this condition? [_] 1. PHC [_] 2.CHC [_] 3.SDH [_] 4.DH [_] 5.MCH [_] 6. Private	
G	Have you ever been prescribed any **medication/Inhaler/Hearing aid/** for this condition by a doctor?	[_] Yes [_] No [_] NA
*If yes, continue to **H**. If no, go to **J***		
H	If **yes**, are you still **continuing** it?	[_] Yes [_] No [_] NA
I	If **No**, what was the reason for **stopping** it?	
J	Are you taking any medication for this condition that wasn't prescribed by a doctor or nurse? (e.g. you bought it at a pharmacy or given to you by a relative)?	[_] Yes [_] No
K	Have you ever consulted **any other treatment** for this condition? [_]1. Ayurveda [_] 2. Traditional Healer [_] 3. Faith Healer [_] 4. Home Remedy [_] 5. Others Specify ( )	
L	How much is this condition **limiting your activities**? [_] 1. Not at all [_] 2. A little [_] 3.Somewhat [_] 4. Quite a bit [_] 5. A lot	