

# Hyderabad DXA study

(Funded by the Wellcome Trust, U.K)

## CLINIC QUESTIONNAIRE

Version 2

(Apply study id label here)

(Apply biochemistry id label here)

Subject type:

1= Indian Migrant Study

2=Hyderabad Nutrition Trial

### Participant info:

Name: \_\_\_\_\_

Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Time of glucose load: \_\_\_\_\_:

Consent form	<input type="checkbox"/> [1=Yes; 2=No]	Questionnaire	<input type="checkbox"/> [1=Yes; 2=No]
First blood	<input type="checkbox"/> [1=Yes; 2=No]	Anthropometry	<input type="checkbox"/> [1=Yes; 2=No]
Second blood	<input type="checkbox"/> [1=Yes; 2=No]	Doctor	<input type="checkbox"/> [1=Yes; 2=No]
DXA	<input type="checkbox"/> [1=Yes; 2=No]	Reimbursement	<input type="checkbox"/> [1=Yes; 2=No]

DXA needed	<input type="checkbox"/> [1=Yes; 2=No]	Second blood needed	<input type="checkbox"/> [1=Yes; 2=No]
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Supported by



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

&  
UNIVERSITY OF BRISTOL, U.K.

**SECTION A: Consent form**

**Nutritional challenges, abdominal adiposity and type 2 diabetes in Indians Participant:**

Shri/Smt/Kum (First & Last Name)

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Address (Lane, Town, State, Pin Code)

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I, \_\_\_\_\_ exercising my free power of choice, hereby give my consent to be included as a subject in the clinical study "Nutritional challenges, abdominal adiposity and type 2 diabetes in Indians".

- 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 and 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 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 future research using the sample I give may include genetic research aimed at understanding genetic influences on diseases but the results of these investigations are unlikely to have any implications for you personally
- 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 should not 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.

Printed name of the Participant \_\_\_\_\_

Signature of the Participant \_\_\_\_\_ Date \_\_\_\_\_

Printed name of the Investigator \_\_\_\_\_

Signature of the Investigator \_\_\_\_\_ Date \_\_\_\_\_

## SECTION: Reimbursement

<b>Summary sheet (to be completed at time of reimbursement)</b>		
	<b>Reimbursement</b>	
1.1	Reimbursement given	<input type="checkbox"/> [1=Yes; 2=No]
1.2	Identity proof taken	<input type="checkbox"/> [1=Yes; 2=No]
	<b>Subject recall</b>	
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	<b>If recalled, clinic visit details</b>	
	(a) Date of clinic visit [DD/MM/YY]	(b) Travel [1=Self; 2=Team]
	(c) Outcome [1=Yes; 2=No]	
	___/___/___	
	___/___/___	
	___/___/___	
1.10	<b>Summary sheet notes</b>	
	<b>Accelerometer</b>	
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	_____ _____ _____

## SECTION B: Blood Sampling

<b>Blood sampling</b>	
<b>2.1</b>	Any illness within the last week? <input type="checkbox"/> [1=Yes; 2=No]
<b>2.2</b>	If yes, specify what illness: _____
<b>2.3</b>	(a) Was this illness or some other reason responsible for reduction in food intake over the last week? <input type="checkbox"/> 1=No reduction 2=Minor reduction 3=Major reduction
	(b) Do you have diabetes? <input type="checkbox"/> [1=Yes; 2=No] <b>[IF YES, DO NOT GIVE GLUCOSE LOAD OR TAKE SECOND BLOOD]</b>
	(c) Are you pregnant? <input type="checkbox"/> [1=Yes; 2=No] <b>[ IF YES, DO NOT GIVE GLUCOSE LOAD OR TAKE SECOND BLOOD ]</b>
<b>2.4</b>	Day of last meal <input type="checkbox"/> [1=Today; 2=Yesterday]
<b>2.5</b>	Time of last meal <input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> [Hours: minutes; 24-hour clock]
<b>2.6</b>	Time blood taken: sample 1 <input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> [Hours: minutes; 24-hour clock]
<b>2.7</b>	Glucose load given <input type="checkbox"/> [1=Yes; 2=No]
<b>2.8</b>	Time glucose load <input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> [Hours: minutes; 24-hour clock]
<b>2.9</b>	Time blood taken: sample 2 <input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> [Hours: minutes; 24-hour clock]
	<b>Success in blood sampling</b>
	<b>(a) Volume</b>
	<b>(b) Clot formation</b>
<b>2.10</b>	Red capped tube <input type="checkbox"/> [1=No; 2=Partial; 3=Complete] <input type="checkbox"/> [1=Yes; 2=No]
<b>2.11</b>	Purple capped tube 1 <input type="checkbox"/> [1=No; 2=Partial; 3=Complete] <input type="checkbox"/> [1=Yes; 2=No]
<b>2.12</b>	Grey capped tube <input type="checkbox"/> [1=No; 2=Partial; 3=Complete] <input type="checkbox"/> [1=Yes; 2=No]
<b>2.13</b>	Purple capped tube 2 <input type="checkbox"/> [1=No; 2=Partial; 3=Complete] <input type="checkbox"/> [1=Yes; 2=No]
<b>2.14</b>	Grey capped tube 2 <input type="checkbox"/> [1=No; 2=Partial; 3=Complete] <input type="checkbox"/> [1=Yes; 2=No]
<b>2.15</b>	(a) Any other comments on blood sample <input type="checkbox"/> [1=Yes; 2=No]
	(b) If yes, specify _____

### SECTION C: Clinical Questionnaire

Interview details	
<b>3.1</b>	Date of quest. completion ____ / ____ / ____ [DD/MM/YY]
<b>3.2</b>	Time of quest. Completion <input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> [Hours: minutes; 24-hour clock]
<b>3.3</b>	Interviewer code <input type="text"/> <input type="text"/>
<b>3.4</b>	Interviewer initials <input type="text"/> <input type="text"/> <input type="text"/>
<i>First of all I would like to collect some details about you and where you live at present</i>	
Contact details	
<b>4.1</b>	Family name _____ [Surname]
<b>4.2</b>	First name/middle name _____ [Forename/other name]
<b>4.3</b>	Current house address (if any) [House No./Street/Locality] _____ _____
<b>4.4</b>	Place name _____ [Name of Village/Town/City]
<b>4.5</b>	PIN Code <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<b>4.6</b>	Sub-district _____ [Tehsil/Taluk/Mandal/Municipality]
<b>4.7</b>	District _____
<b>4.8</b>	Nearest railway station _____
<b>4.9</b>	Nearest big town _____ [In case of village only]
<b>4.10</b>	State _____ [Name of country if abroad]
<b>4.11</b>	Type of place <input type="checkbox"/> [1=Village; 2=Town; 3=Small city; 4=Large city]
<b>4.12</b>	Travelling by road or rail, total average journey time between this place and NIN <input type="text"/> <input type="text"/> <input type="text"/> [In completed hours]
<b>4.13</b>	Census code <input type="text"/> <input type="text"/>
<b>4.14</b>	Home telephone number (landline) ( <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> ) <input type="text"/> <input type="text"/> [Area code] [Phone number]
<b>4.15</b>	Mobile number <input type="text"/> <input type="text"/>

		<i>Now I would like to collect some personal information about you</i>
		<b>Personal details</b>
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]
5.4	Year of birth	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> [YYYY]
5.5	Sex	<input type="checkbox"/> [1=Male; 2=Female]
5.6	(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]
5.7	Current marital status	<input type="checkbox"/> 1=Never married 2=Married 3=Widow/widower 4=Separated/divorced
5.8	<b><i>If ever married:</i></b>	
	(a) How old were you when you first started living with your spouse after your marriage?	<input type="text"/> <input type="text"/> [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="text"/> <input type="text"/> [Enter 00 if None]
5.10	How many (live) daughters do you have?	<input type="text"/> <input type="text"/> [Enter 00 if None]
		<b>Primary occupation</b>
5.11	(a) Respondent: <input type="checkbox"/>	(b) Spouse (if married): <input type="checkbox"/>
	1=At home doing housework	4= Student/ training
	2=Unemployed, not seeking work: retired/ disabled	5=Unskilled manual
	3=Unemployed, seeking work	6=Semi-skilled manual
		7=Skilled manual
		8=Skilled non-manual
		9=Semi-Professional
		10=Professional
5.12	Briefly describe your job:	_____
		<b>Highest educational level attained</b>
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)
	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=Kutchra 2=Semi-pucca 3=Pucca
6.3	What is the main source of lighting for your household? <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]
<b>SKIP QUESTIONS 6.7-6.10 IF LIVING IN HOSTEL/SHARED ACCOMMODATION</b>	
6.7	Including yourself, how many people normally live in your household? <input type="checkbox"/> <input type="checkbox"/> [Number of People]
6.8	How many rooms are there in your household? (count all rooms including kitchen, bathroom, etc) <input type="checkbox"/> <input type="checkbox"/> [Number of Rooms]
6.9	Does this household own any agricultural land? <input type="checkbox"/> [1=Yes; 2=No]
6.10	<b>Does the household own any of the following:</b>
	(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]



## ALL PARTICIPANTS

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

<b>Health and lifestyle</b>						
<b>8.1</b>		(i) Have you ever used tobacco on a <b>REGULAR</b> 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
	(a) Smoked	<input type="checkbox"/> 1=Never <input type="checkbox"/> 2=Former (stopped >6 months) <input type="checkbox"/> 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"/>
	(b) Chewed	<input type="checkbox"/> 1=Never <input type="checkbox"/> 2=Former (stopped >6 months) <input type="checkbox"/> 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"/>
	(c) Snuffed	<input type="checkbox"/> 1=Never <input type="checkbox"/> 2=Former (stopped >6 months) <input type="checkbox"/> 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"/>
<b>8.2</b>	(a) Is there someone in your household who smokes tobacco at home? <b>[If no, skip to 8.3]</b>				<input type="checkbox"/> [1=Yes; 2=No]	
	<i>If yes,</i> (b) How many cigarettes or bedis does this person smoke per day?				<input type="text"/> <input type="text"/> <input type="text"/> bedis /cigarettes per day	
<b>8.3</b>	(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? <b>[If no, skip to 8.4]</b>				<input type="checkbox"/> [1=Yes; 2=No]	
	<i>If yes,</i> (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?				<input type="text"/> <input type="text"/> [Hours] [00 if none]	
	(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]	
<b>8.4</b>	Would you describe your present alcohol intake as?			<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		

<i>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.</i>			
<b>Quality of life</b>			
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"/> %
<b>Depression</b>			
	<i>Over the <u>last 2 weeks</u>, how often have you been bothered by any of the following problems?</i>	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 <u>last 4 weeks</u> , have you had an anxiety attack – suddenly feeling fear or panic	<input type="checkbox"/> [1=Yes; 2=No]	

<b>IF NO, SKIP QUESTIONS 9.17-9.20 AND GO TO QUESTION 9.21</b>	
<i>If yes,</i>	
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
<i>In the <b>last 4 weeks</b>, how much have you been bothered by any of the following problems?</i>	
	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 <b>recently</b> <input type="checkbox"/>
9.30	Thinking or dreaming about something terrible that had happened to you <b>in the past</b> – like your house being destroyed, a severe accident, being hit or assaulted, or being forced to commit a sexual act <input type="checkbox"/>

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

<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 <b>LAST WEEK</b>.</p> <p><b>In case you travelled for a long duration to reach this place, or stayed back in this city for a few days, please recall the activities of the week before you left to this city.</b></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>			
<b>Work related activity</b>			
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] <b>[IF NO, SKIP TO 11.8]</b>	
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="text"/> <input type="text"/> <input type="text"/> <input type="text"/> [In completed half hours]	
<b>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 (completed half hours):</b>			
	(a) <b>Standing:</b> E.g. talk, lab work, supervise, mild cleaning, cattle grazing done standing.	(b) <b>Sitting:</b> E.g. typing, computer work, cleaning grains, eating lunch, driving for your work, etc	(c) <b>Walking:</b> E.g. walking around, strolling, walking with light loads
	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> [hours]	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> [hours]	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> [hours]
11.4	<b>If you spend any time at work on activities more strenuous than walking, please list these:</b>		
		(i) Took part in this activity	(ii) Days per week
			(iii) Total duration per day
	(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	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> [mts]
	(i) Harvesting	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> days	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> [mts]
	(j) Any others?	<input type="checkbox"/> [1=Yes; 2=No]		
	(k) _____		<input type="checkbox"/> days	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> [mts]
	(l) _____		<input type="checkbox"/> days	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> [mts]
	(m) _____		<input type="checkbox"/> days	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> [mts]
<b>Travel to and from work</b>				
<i>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.</i>				
			(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="checkbox"/> days	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> [mts]
11.6	During the last week, on how many days did you cycle to and from work?	<input type="checkbox"/> days	<input type="checkbox"/> days	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> [mts]
11.7	During the last week, on how many days did you walk to and from work?	<input type="checkbox"/> days	<input type="checkbox"/> days	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> [mts]
<b>Travel apart from to and from work</b>				
<i>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.</i>				
			(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="checkbox"/> days	<input type="checkbox"/> days	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> [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="checkbox"/> days	<input type="checkbox"/> days	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> [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="checkbox"/> days	<input type="checkbox"/> days	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> [mts]
<i>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</i>				
<b>Sports / games / exercise</b>				
<i>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.</i>				
	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="checkbox"/> days	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> [mts]
	(b) Walking brisk speed for leisure	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> days	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> [mts]
	(c) Jogging/Running	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> days	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> [mts]

	(d) Badminton	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> days	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> [mts]
	(e) Cricket	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> days	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> [mts]
	(f) Yoga	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> days	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> [mts]
	(g) Swimming	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> days	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> [mts]
	(h) Football	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> days	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> [mts]
	(i) Volleyball	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> days	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> [mts]
	(j) Kabbadi	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> days	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> [mts]
	(k) Cycling	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> days	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> [mts]
	(l) Khokho	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> days	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> [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) _____		<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]

<b>11.13 Sedentary activities</b>				
<i>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.</i>				
	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="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> [mts]
	(b) Computer/computer games/internet for leisure	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> days	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> [mts]
	(c) Watching TV/ movies	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> days	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> [mts]
	(d) Indoor games (e.g. chess, carom, playing cards)	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> days	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> [mts]
	(e) Prayer/meditation	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> days	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> [mts]
	(f) Listening to music/radio	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> days	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> [mts]
	(g) Sewing /embroidery/ knitting	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> days	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> [mts]
	(h) Socialising (talking outside working hours or on phone)	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> days	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> [mts]
	(i) Any others?	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> days	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> [mts]
	(j) _____		<input type="checkbox"/> days	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> [mts]
	(k) _____		<input type="checkbox"/> days	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> [mts]
	(l) _____		<input type="checkbox"/> days	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> [mts]

**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”.*

	<b>CEREALS</b>	<b>Portion Size</b>	<b>(a) Average consumption</b>	<b>(b) Per Day<sup>1</sup></b>	<b>(b) Per Week<sup>2</sup></b>	<b>(b) Per Month<sup>3</sup></b>	<b>(b) Per Year/ Never<sup>4</sup></b>
<b>12.1</b>	Chapathis / roti	No					
<b>12.2</b>	Parathas / naan	No					
<b>12.3</b>	Jowar roti	No					
<b>12.4</b>	Poori, bhatura	No					
<b>12.5</b>	Plain rice	Bowl					
<b>12.6</b>	Mutton, chicken biriyani	Bowl					
<b>12.7</b>	Lime rice, puliogare, veg biriyani	Bowl					
<b>12.8</b>	Bhagar	Bowl					
<b>12.9</b>	Upma	Bowl					
<b>12.10</b>	Idlis	No					
<b>12.11</b>	Dosa / uthappam	No					
<b>12.12</b>	Pesarattu	No					
<b>12.13</b>	Attakalu	Bowl					
<b>12.14</b>	Rice, ragi porridge	Bowl					
<b>12.15</b>	Corn flakes	Bowl					
<b>12.16</b>	Bread, Toast, Rolls, Buns	No					
<b>12.17</b>	Noodles, pasta etc	Bowl					
	<b>LENTILS / DHALS / GRAVIES</b>						
<b>13.1</b>	Plain dhal sambar	Ladle					
<b>13.2</b>	Dhal sambar with vegetables	Ladle					
<b>13.3</b>	Channa, rajma, dry peas etc. curry	Ladle					
<b>13.4</b>	Green leafy vegetable curry	Ladle					
<b>13.5</b>	Rasam, all types	Ladle					
	<b>CHUTNEYS / SALAD / PAPAD</b>						
<b>14.1</b>	Raw vegetable salad	Tbsp					

		Portion Size	(a) Average consumption	(b) Per Day <sup>1</sup>	(b) Per Week <sup>2</sup>	(b) Per Month <sup>3</sup>	(b) Per Year/ Never <sup>4</sup>
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					
<b>NON – VEGETARIAN</b>							
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					
<b>MILK &amp; BEVERAGES</b>							
16.1	Tea	Glass					
16.2	Coffee	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					
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					

	<b>MISCELLANEOUS</b>	Portion Size	<b>(a) Average consumption</b>	<b>(b) Per Day<sup>1</sup></b>	<b>(b) Per Week<sup>2</sup></b>	<b>(b) Per Month<sup>3</sup></b>	<b>(b) Per Year/ Never<sup>4</sup></b>
17.1	Ghee/ butter	Tsp					
17.2	Jam	Tsp					
17.3	Sugar	Tsp					
	<b>SNACKS/ SWEETS/DESSERTS</b>						
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/goodday/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					
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					

	<b>FRUITS</b>	<b>Portion size</b>	<b>(a) Average consumption</b>	<b>(b) Per Day<sup>1</sup></b>	<b>(b) Per Week<sup>2</sup></b>	<b>(b) Per Month<sup>3</sup></b>	<b>(b) Per Year/ Never<sup>4</sup></b>	<b>(c) Seasonal (cross if seasonal)</b>
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						
	<b>VEGETABLES</b>							
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						
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?	<input type="checkbox"/> 1=Sunflower oil    2=Groundnut oil    3=Coconut oil 4=Palm oil    5=Mustard oil    6=Dalda /vanaspathi 7=Butter    8=Ghee    9=Olive oil 10=Corn oil    11=Rice bran oil    12=Soya bean oil		
21.2	How many coconuts do you use for cooking in a month?	<input type="checkbox"/> <input type="checkbox"/> [No / month]    [00 if none]		
21.3	(a) What type of milk do you regularly consume?	<input type="checkbox"/> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> 1=Whole milk 2=Skimmed milk 3=Toned milk </div> <div style="width: 45%;"> 4=Skimmed milk powder 5=Whole and toned milk 6=Other </div> </div>		
(b) If other, then specify _____				
21.4	(a) Do you consume any vitamin or mineral supplement at least once a week? <input type="checkbox"/> [1=Yes; 2=No]			
<i>If Yes, (b) Brand name / Type</i>		<i>(c) Dosage(mg)</i>	<i>(d) No. / week</i>	
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 _____			
	<i>If yes,</i> (h) Since how many years are you on this special diet?	<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

<b>Medical history</b>	
<b>22.16</b>	Is your father still alive? (a) <input type="checkbox"/> [1=Yes; 2=No] (b) <i>If no, his age at death</i> <input type="text"/> <input type="text"/> [years]
<b>22.17</b>	(a) <i>If no, what was the cause of his death?</i> <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) <i>If "other" specify:</i>
Did/does your father suffer from any of the following?	
<b>22.18</b>	Diabetes <input type="checkbox"/> [1=Yes; 2=No; 3=Don't know]
<b>22.19</b>	High blood pressure <input type="checkbox"/> [1=Yes; 2=No; 3=Don't know]
<b>22.20</b>	Heart disease <input type="checkbox"/> [1=Yes; 2=No; 3=Don't know]
<b>22.21</b>	Overweight/obesity <input type="checkbox"/> [1=Yes; 2=No; 3=Don't know]
<b>22.22</b>	Lung disease <input type="checkbox"/> [1=Yes; 2=No; 3=Don't know]
<b>22.23</b>	Is your mother still alive? (a) <input type="checkbox"/> [1=Yes; 2=No] (b) <i>If no, her age at death</i> <input type="text"/> <input type="text"/> [years]
<b>22.24</b>	(a) <i>If no, what was the cause of her death?</i> <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) <i>If "other" specify:</i>
Did/does your mother suffer from any of the following?	
<b>22.25</b>	Diabetes <input type="checkbox"/> [1=Yes; 2=No; 3=Don't know]
<b>22.26</b>	High blood pressure <input type="checkbox"/> [1=Yes; 2=No; 3=Don't know]
<b>22.27</b>	Heart disease <input type="checkbox"/> [1=Yes; 2=No; 3=Don't know]
<b>22.28</b>	Overweight/obesity <input type="checkbox"/> [1=Yes; 2=No; 3=Don't know]
<b>22.29</b>	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?	
<b>22.30</b>	Diabetes <input type="checkbox"/> [1=Yes; 2=No; 3=Don't know; 4=no brothers]
<b>22.31</b>	High blood pressure <input type="checkbox"/> [1=Yes; 2=No; 3=Don't know; 4=no brothers]
<b>22.32</b>	Heart disease <input type="checkbox"/> [1=Yes; 2=No; 3=Don't know; 4=no brothers]
<b>22.33</b>	Overweight/obesity <input type="checkbox"/> [1=Yes; 2=No; 3=Don't know; 4=no brothers]
<b>22.34</b>	Lung disease <input type="checkbox"/> [1=Yes; 2=No; 3=Don't know; 4=no brothers]
<b>23.1</b>	(a) Have you had wheezing or whistling in your chest at any time in the last year? <input type="checkbox"/> [1=Yes; 2=No]
	<i>If yes,</i> (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]

**INDIAN MIGRANT STUDY PARTICIPANTS ONLY**

<b>24.1</b>	(a) Do you usually cough when you don't have a cold? <b>[If no, skip to 24.2]</b>	<input type="checkbox"/> [1=Yes; 2=No]
	<i>If yes</i> (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="text"/> <input type="text"/> [Years]
<b>24.2</b>	(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? <b>[If no, skip to 24.3]</b>	<input type="checkbox"/> [1=Yes; 2=No]
	<i>If yes,</i> (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="text"/> <input type="text"/> [Years]
<b>24.3</b>	(a) Are you unable to walk due to a condition other than shortness of breath? <b>[If no, skip to 24.4]</b>	<input type="checkbox"/> [1=Yes; 2=No]
	(b) <i>If yes,</i> name of condition _____	
<b>24.4</b>	<b>If able to walk:</b> (a) Are you troubled by shortness of breath when hurrying on the level or walking up a slight hill? <b>[If no, skip to 24.5]</b>	<input type="checkbox"/> [1=Yes; 2=No]
	<i>If yes,</i> (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]
<b>24.5</b>	(a) Have you ever had any pain or discomfort in your chest? <b>[If no, end section]</b>	<input type="checkbox"/> [1=Yes; 2=No]
	<i>If yes,</i> (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]
	<b>If no pain on walking, end section. Otherwise ask d-g</b>	
	(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]	
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]	
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]	
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]	
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]	
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]	
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]	
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]	
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]	
	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]
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]
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]
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]
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]
25.17	Caliper number	<input type="text"/>		
	Muscle strength	Reading		
25.18	Right hand	<input type="text"/> <input type="text"/> . <input type="text"/> [kg]		
25.19	Left hand	<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	<hr/>
25.26	All measurements adequate	<input type="checkbox"/> [1=Yes; 2=No]
25.27	If not, specify	<hr/>

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="text"/>		
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	<hr/>		

Respiratory function						
27.1	In the past three months have you had any surgery on your chest or abdomen?					<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]
<b>If any of the questions 27.1 to 27.8 is “yes”, do NOT proceed with the test</b>						
27.9	(a) Have you taken medication for breathing in last 6 hours?					<input type="checkbox"/> [1=Yes; 2=No]
<i>If yes, name of medication:</i> _____						
27.10	Have you had a respiratory infection (cold) in the last three weeks?					<input type="checkbox"/> [1=Yes; 2=No]
<b>TAKE VERBAL CONSENT TO DO THE TEST</b>						
		<b>a) Blow 1</b>	<b>b) Blow 2</b>	<b>c) Blow 3</b>	<b>d) Blow 4</b>	<b>e) Blow 5</b>
27.11	FEV <sub>1</sub>	<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"/>
27.12	FVC	<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"/>
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 ( <b>women only</b> )		
Reproductive history		
<b>28.1</b>	At what age did your periods start?	<input type="text"/> <input type="text"/> [Age in completed years]
<b>28.2</b>	(a) Do you still menstruate?	<input type="checkbox"/> [1=Yes; 2=No]
	(b) <i>If no</i> , at what age did your periods stop?	<input type="text"/> <input type="text"/> [Age in completed years]
	(c) <i>If yes</i> , do you have irregular/infrequent menstrual cycles?	<input type="checkbox"/> [1=Yes; 2=No]
	(d) <i>If yes</i> , how many periods do you have in a year?	<input type="text"/> <input type="text"/> [Number]
<b>28.3</b>	Do you have excess hair growth on your upper lip, chin, lower abdomen or inner thighs?	<input type="checkbox"/> [1=Yes; 2=No]
<b>28.4</b>	(a) Have you ever taken the oral contraceptive pill?	<input type="checkbox"/> [1=Yes; 2=No]
	(b) <i>If yes</i> , 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) <i>If yes</i> , for how long did you take it?	<input type="text"/> <input type="text"/> [Completed years]
<b>28.5</b>	(a) Have you ever been pregnant?	<input type="checkbox"/> [1=Yes; 2=No]
	(b) <i>If yes</i> , at what age was your first pregnancy?	<input type="text"/> <input type="text"/> [Age in completed years]
	(c) <i>If yes</i> , how many pregnancies have you had?	<input type="text"/> <input type="text"/> [Total number, 00 if none]
	(d) <i>If yes</i> , how many live births have you had?	<input type="text"/> <input type="text"/> [Total number, 00 if none]
	(e) <i>If yes</i> , how many miscarriages/stillbirths have you had?	<input type="text"/> <input type="text"/> [Total number, 00 if none]
	(f) <i>If yes</i> , how many induced abortions have you had?	<input type="text"/> <input type="text"/> [Total number, 00 if none]
		<b>[Check that c = d + e + f]</b>
<b>28.6</b>	Have you ever tried to become pregnant during a period of one year or more without success?	<input type="checkbox"/> [1=Yes; 2=No]
<b>28.7</b>	(a) Are you pregnant at the moment?	<input type="checkbox"/> [1=Yes; 2=No]
	(b) <i>If yes</i> , which trimester of pregnancy are you in?	<input type="checkbox"/> [1, 2 or 3]

**SECTION E: DXA Measurements**

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

## SECTION F: Coronary Measures and Medical History

Medical history.			
	(a) Have you been diagnosed with any of the following conditions?		(b) <i>If yes</i> , age when diagnosed
<b>30.2</b>	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]	
<b>30.3</b>	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]	
<b>30.4</b>	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]	
<b>30.5</b>	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]	
<b>30.6</b>	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:	_____	
	(f) Who diagnosed condition	<input type="checkbox"/> [1=allopathic doctor; 2=homeopath; 3=ayurvedic doctor 4=RMP – registered medical practitioner; 5=Other]	

<b>30.7</b>	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:	_____	
<b>30.8</b>	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]
	Name of medicine:	_____	
<b>30.9</b>	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]
	Name of medicine:	_____	
<b>30.10</b>	Peptic ulcer	(a) <input type="checkbox"/> [1=Yes; 2=No]	(b) <input type="checkbox"/> <input type="checkbox"/> [Age in completed years]
<b>30.11</b>	COPD	(a) <input type="checkbox"/> [1=Yes; 2=No]	(b) <input type="checkbox"/> <input type="checkbox"/> [Age in completed years]
<b>30.12</b>	Emphysema	(a) <input type="checkbox"/> [1=Yes; 2=No]	(b) <input type="checkbox"/> <input type="checkbox"/> [Age in completed years]
<b>30.13</b>	Chronic bronchitis	(a) <input type="checkbox"/> [1=Yes; 2=No]	(b) <input type="checkbox"/> <input type="checkbox"/> [Age in completed years]
<b>30.14</b>	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>	_____	
<b>MEDICAL EXAMINATION</b>			
	<b>Carotid IMT</b>	<b>(a) Far wall</b>	<b>(b) Near wall</b>
<b>31.1</b>	Right common carotid artery image taken	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> [1=Yes; 2=No]
<b>31.2</b>	Any problems taking images	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> [1=Yes; 2=No]
<b>31.3</b>	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="checkbox"/> [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]		
		<b>(a) First measure</b>	<b>(b) Second measure</b>	<b>(c) Third measure</b>
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]		
		<b>(a) First measure</b>	<b>(b) Second measure</b>	<b>(c) Third measure</b>
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]
Arterial Stiffness				
		<b>(a) First measure</b>	<b>(b) Second measure</b>	<b>(c) Third measure</b>
33.1	Radial augmentation	<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]
33.2	Radial 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"/> %
33.3	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]
33.4	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]
33.5	Mean arterial pressure	<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]
33.6	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]
33.7	Any problems taking readings	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> [1=Yes; 2=No]	<input type="checkbox"/> [1=Yes; 2=No]
33.8	If yes, specify reason	_____		

