



12/1/98

SOUTH AFRICAN DEMOGRAPHIC AND HEALTH SURVEY ADULT HEALTH QUESTIONNAIRE

IDENTIFICATION																						
PROVINCE _____	<table border="1" style="margin: auto;"> <tr><td> </td><td> </td><td> </td></tr> </table>																					
DISTRICT _____																						
EA NUMBER																						
EA TYPE																						
SADHS CLUSTER NUMBER																						
HOUSEHOLD NUMBER																						
NAME AND LINE NUMBER OF ADULT _____																						
NAME OF HOUSEHOLD HEAD _____																						

INTERVIEWER VISITS				
	1	2	3	FINAL VISIT
DATE	_____	_____	_____	DAY _____ MONTH _____ YEAR _____
INTERVIEWER'S NAME	_____	_____	_____	NAME _____
RESULT*	_____	_____	_____	RESULT _____
NEXT VISIT: DATE	_____	_____		TOTAL NO. OF VISITS _____
TIME	_____	_____		
*RESULT CODES: 1 COMPLETED 4 REFUSED 7 OTHER _____ (SPECIFY) 2 NOT AT HOME 5 PARTLY COMPLETED 3 POSTPONED 6 INCAPACITATED				

LANGUAGE													
LANGUAGE OF QUESTIONNAIRE	<table border="1" style="margin: auto;"> <tr><td> </td><td>0</td><td>1</td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </table>		0	1									
		0	1										
LANGUAGE OF INTERVIEW													
HOME LANGUAGE OF RESPONDENT													
TRANSLATOR USED (YES = 1, NO = 2)													
LANGUAGE CODES													
01 ENGLISH 04 isi ZULU 07 SePEDI 10 ZITSONGA													
02 AFRIKAANS 05 SeSOTHO 08 SiSWATI 11 isiNDEBELA													
03 isiXHOSA 06 SeTSWANA 09 TshiVENDA													

SUPERVISOR	FIELD EDITOR	OFFICE EDITOR	KEYED BY
NAME _____	NAME _____	_____	_____
DATE _____	DATE _____	_____	_____

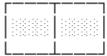
J	Home Based Care Services/House visits?	YES 1	NO 2 ↘	YES 1 ↘	NO 2	LONG WAIT 01 SHORT CONSULTATION 02 STAFF RUDE/UNKIND 03 DIDN'T SEE DOCTOR 04 OTHER 96 (SPECIFY)	
K	Dentist/Oral hygienist/Oral therapist?	YES 1	NO 2 ↘	YES 1 ↘	NO 2	LONG WAIT 01 SHORT CONSULTATION 02 STAFF RUDE/UNKIND 03 DIDN'T SEE DOCTOR 04 OTHER 96 (SPECIFY)	
L	Other? _____	YES 1	NO 2				
4.	Are you covered by a Medical Aid or Medical Benefit Scheme? (Any scheme that helps you pay for health/drug services)					YES 1 NO 2	→8
5.	Have you had your blood pressure measured in the past 12 months?					YES 1 NO 2	
6.	Do you know what your blood pressure is?					YES 1 NO 2	
7.	Is it high, normal or low?					HIGH 1 NORMAL 2 LOW 3 DON'T KNOW 8	

SECTION 2: FAMILY MEDICAL HISTORY

8	Now I would like to ask you about your family. Do you have a close blood relative (father, mother, brother, sister or child) who has ever had any of the following conditions:		
8A	High Blood Pressure?	YES 1 NO 2 DON'T KNOW 8	
8B	Heart attack or angina or chest pain when exerting himself/herself?	YES 1 NO 2 DON'T KNOW 8	↘ 8D
8C	IF "YES", was it before the age of 50 years?	YES 1 NO 2 DON'T KNOW 8	
8D	Stroke?	YES 1 NO 2 DON'T KNOW 8	
8E	High blood cholesterol or Fats?	YES 1 NO 2 DON'T KNOW 8	
8F	Diabetes or Blood Sugar?	YES 1 NO 2 DON'T KNOW 8	
8G	Cancer?	YES 1 NO 2 DON'T KNOW 8	

SECTION 3: CLINICAL CONDITIONS

9	Now I would like to ask you about your own health. Has a doctor or nurse or staff member at a clinic or at hospital told you that you had or have any of the following conditions:						
9A	High Blood Pressure?	YES 1 NO 2 DON'T KNOW 8	└─>9C				
9B	IF "YES", when was the first time that you were told you had high blood pressure?	IN THE LAST 12 MONTHS 1 MORE THAN A YEAR AGO 2					
9C	Heart attack or angina?	YES 1 NO 2 DON'T KNOW 8	└─>9E				
9D	IF "YES", when was your heart attack or angina?	IN THE LAST 12 MONTHS 1 MORE THAN A YEAR AGO 2					
9E	Stroke?	YES 1 NO 2 DON'T KNOW 8	└─>9G				
9F	IF "YES", when did you have your stroke?	IN THE LAST 12 MONTHS 1 MORE THAN A YEAR AGO 2					
9G	High blood cholesterol or fats?	YES 1 NO 2 DON'T KNOW 8	└─>9I				
9H	IF "YES", when was the first time that you were told that you had blood cholesterol or fats?	IN THE LAST 12 MONTHS 1 MORE THAN A YEAR AGO 2					
9I	Diabetes or Blood Sugar?	YES 1 NO 2 DON'T KNOW 8	└─>9K				
9J	IF "YES", when was the first time that you were told that you had diabetes or blood sugar?	IN THE LAST 12 MONTHS 1 MORE THAN A YEAR AGO 2					
9K	Emphysema/Bronchitis?	YES 1 NO 2 DON'T KNOW 8	└─>9M				
9L	IF "YES", when was the first time that you were told that you had emphysema or bronchitis?	IN THE LAST 12 MONTHS 1 MORE THAN A YEAR AGO 2					
9M	Asthma?	YES 1 NO 2 DON'T KNOW 8	└─>9O				
9N	IF "YES" when was the first time that you were told that you had asthma?	IN THE LAST 12 MONTHS 1 MORE THAN A YEAR AGO 2					
9O	TB?	YES 1 NO 2 DON'T KNOW 8	└─>9Q				
9P	IF "YES" when was the first time that you were told that you had TB?	IN THE LAST 12 MONTHS 1 MORE THAN A YEAR AGO 2					
9PP	How many episodes of TB have you ever been treated for?	<table border="1"> <tr> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> </tr> </table>					
9Q	Cancer?	YES 1 NO 2 DON'T KNOW 8	└─>12				
9R	IF "YES", when was the first time that you were told that you had cancer?	IN THE LAST 12 MONTHS 1 MORE THAN A YEAR AGO 2					

10	Did the doctor/nurse/staff member at a hospital tell you what kind of cancer you have?	YES 1 NO 2 DON'T KNOW 8	 → 12
11	What kind of cancer were you told you had or have? DO NOT READ THE LIST OF CANCERS.	LUNG CANCER A CERVICAL/WOMB CANCER B SKIN CANCER C BREAST CANCER D PROSTATE CANCER E ESOPHAGEAL CANCER F OTHER _____ X (SPECIFY)	
12	Do you feel you have less breath when exerting yourself when compared to other people your age?	YES 1 NO 2 DON'T KNOW 8	
13	During the last year have you had wheezing or tightness of your chest.	YES 1 NO 2 DON'T KNOW 8	 → 16
14	If "YES" were you also short of breath?	YES 1 NO 2 DON'T KNOW 8	
15	Do you only get wheezing when you have a cold?	YES 1 NO 2 DON'T KNOW 8	
16	Is your sleep ever interrupted by you coughing?	YES 1 NO 2 DON'T KNOW 8	
17	Is your sleep ever interrupted by wheezing or a tight chest?	YES 1 NO 2 DON'T KNOW 8	
18	Do you usually cough?	YES 1 NO 2 DON'T KNOW 8	 → 21
19	When you cough, do you usually bring up phlegm from your chest?	YES 1 NO 2 DON'T KNOW 8	 → 21
20	If "yes", have you brought up phlegm every day for at least three months during the last year?	YES 1 NO 2 DON'T KNOW 8	 → 21
20A	If "yes" for how many years have you brought up phlegm in this way?		
21	IS THE RESPONDENT A MAN OR A WOMAN?	MAN  WOMAN 	 → 26
22	Now I am going to ask you some personal questions. Please remember that this information will be kept strictly confidential. Some men experience pain during urination or have a discharge from the penis. During the last 3 months, have you noticed any such pain or discharge?	YES 1 NO 2	
24	Some men experience sores in the genital area. During the last 3 months, have you noticed any such sores?	YES 1 NO 2	

SECTION 4: DENTAL HEALTH

26	Now I want to ask you about your teeth. Do you think that there is anything wrong in your mouth, teeth or gums?	YES 1 NO 2	→2 8
27	Which of the following items do you feel is a problem: Your Teeth? Your Gums? Ulcers/sores in the mouth? Dentures? Any other problems? RECORD ALL MENTIONED.	TEETH A GUMS B ULCERS/SORES IN THE MOUTH ... C DENTURES D OTHER _____ X (SPECIFY)	
28	Have you ever visited a dentist, an oral hygienist, or an oral therapist ?	YES 1 NO 2	
29	Have you lost any of your natural teeth?	YES 1 NO 2	→34
30	Do you have any of your natural teeth?	YES 1 NO 2	
31	Do you wear a denture (false teeth)?	YES, PARTIAL 1 YES, TOTAL/COMPLETE 2 NO 3	
32	CHECK 30: HAS NO NATURAL TEETH 	HAS NATURAL TEETH 	→ 34
33	Do you usually rinse or clean your mouth everyday?	YES 1 NO 2	→ 38
34	What do you do to look after your teeth. Do you Clean/Brush your teeth? Watch your diet/Eat special foods? Visit the dentist? Anything else?	YES NO CLEAN/BRUSH 1 2 DIET/FOOD 1 2 VISIT DENTIST 1 2 OTHER _____ 1 2 (SPECIFY)	
35	CHECK 34: CLEAN/BRUSH 	DOES NOT CLEAN/BRUSH 	→ 37
36	Do you usually brush/wash your teeth everyday?	YES 1 NO 2	
37	Do you own a toothbrush?	YES 1 NO 2	

38	<p>Some people say that fluoride mineral in the water makes the children and adults' natural teeth strong and healthy;</p> <p>Other people say it does not.</p> <p>What do you think?</p>	<p>MAKES TEETH STRONG 1</p> <p>DOES NOT MAKE TEETH STRONG . 2</p> <p>OTHER _____ 6</p> <p style="text-align: center;">(SPECIFY)</p> <p>DON'T KNOW 8</p>
----	---	---

SECTION 5: OCCUPATIONAL HEALTH

39	In the last 12 months, have you worked for payment?	YES 1 NO 2	→45A
40	In the last 12 months, have you had any injury or health problem related to your work?	YES 1 NO 2	→43
41	Did you stay away from work because of this injury or problem?	YES 1 NO 2	
42	What was the injury or health problem?	<div style="border: 1px solid black; width: 100px; height: 20px; margin: 0 auto;"></div> <hr/> <hr/>	
43	In the last 12 months, have you had an existing injury or health problem that was aggravated or became worse at work?	YES 1 NO 2	→45A
44	Did you stay away from work because of this injury or problem?	YES 1 NO 2	
45	What was the injury or health problem?	<div style="border: 1px solid black; width: 100px; height: 20px; margin: 0 auto;"></div> <hr/> <hr/>	
45A	Have you ever worked underground in a mine?	YES 1 NO 2	→46
45B	If "yes", what kind of mine was it? RECORD ALL	GOLD A COAL B ASBESTOS C OTHER _____ X (SPECIFY)	
45C	How many years in total did you work underground?	<div style="border: 1px solid black; width: 100px; height: 20px; margin: 0 auto;"></div>	

SECTION 6: MEDICATION

46	Now I want to ask you about any medication you take. Do you use any medicine regularly that has been prescribed by a doctor or nurse?	YES 1 NO 2 DON'T KNOW 8	↘→65
47	How many different medicines do you use regularly?	NUMBER <input type="text"/> <input type="text"/>	
48	Do you know what the medication is for?	YES 1 NO 2	→→65
49	Is it for High Blood Pressure ?	YES 1 NO 2 DON'T KNOW 8	↘→51
50	Can you name the medication? WRITE DOWN THE NAME(S) OF THE MEDICATION.	YES 1 NO 2 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	→→51
51	Is it for Diabetes/Sugar ?	YES 1 NO 2 DON'T KNOW 8	↘→53

52	<p>Can you name the medication?</p> <p>WRITE DOWN THE NAME(S) OF THE MEDICATION.</p>	<p>YES 1</p> <p>NO 2</p> <p>[] _____ []</p> <p>[] _____ []</p>	<p>→53</p>
53	<p>Is it for High Blood Cholesterol?</p>	<p>YES 1</p> <p>NO 2</p> <p>DON'T KNOW 8</p>	<p>→55</p>
54	<p>Can you name the medication?</p> <p>WRITE DOWN THE NAME(S) OF THE MEDICATION.</p>	<p>YES 1</p> <p>NO 2</p> <p>[] _____ []</p> <p>[] _____ []</p>	<p>→55</p>
55	<p>Is it for Angina/chestpain?</p>	<p>YES 1</p> <p>NO 2</p> <p>DON'T KNOW 8</p>	<p>→57</p>

60	<p>Can you name the medication?</p> <p>WRITE DOWN THE NAME(S) OF THE MEDICATION.</p>	<p>YES 1</p> <p>NO 2</p> <p>[] _____ []</p> <p>[] _____ []</p>	<p>→61</p>
61	<p>Is it for Tuberculosis?</p>	<p>YES 1</p> <p>NO 2</p> <p>DON'T KNOW 8</p>	<p>→63</p>
62	<p>Can you name the medication?</p> <p>WRITE DOWN THE NAME(S) OF THE MEDICATION.</p>	<p>YES 1</p> <p>NO 2</p> <p>[] _____ []</p> <p>[] _____ []</p>	<p>→63</p>
63	<p>Do you take it because you had a Stroke?</p>	<p>YES 1</p> <p>NO 2</p> <p>DON'T KNOW 8</p>	<p>→65</p>

64

Can you name the medication?

YES 1
NO 2

→65

WRITE DOWN THE NAME(S) OF THE MEDICATION.

<input type="checkbox"/>	_____	<input type="checkbox"/>
<input type="checkbox"/>	_____	<input type="checkbox"/>
<input type="checkbox"/>	_____	<input type="checkbox"/>
<input type="checkbox"/>	_____	<input type="checkbox"/>
<input type="checkbox"/>	_____	<input type="checkbox"/>
<input type="checkbox"/>	_____	<input type="checkbox"/>

65

NOW, ASK THE RESPONDENT TO SHOW YOU ALL THE MEDICATION TAKEN EVERY DAY DURING THE LAST MONTH. THEN WRITE DOWN THE NAMES OF ALL THE MEDICATIONS BELOW.

NAME

_____	<input type="checkbox"/>						
_____	<input type="checkbox"/>						
_____	<input type="checkbox"/>						
_____	<input type="checkbox"/>						
_____	<input type="checkbox"/>						
_____	<input type="checkbox"/>						
_____	<input type="checkbox"/>						
_____	<input type="checkbox"/>						
_____	<input type="checkbox"/>						
_____	<input type="checkbox"/>						
_____	<input type="checkbox"/>						
_____	<input type="checkbox"/>						
_____	<input type="checkbox"/>						
_____	<input type="checkbox"/>						
_____	<input type="checkbox"/>						

MEDICATIONS ARE LISTED

YES.....1
NO.....2 →66

NUMBER OF MEDICATIONS LISTED

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

65A

Who pays for most of the prescribed medication that you use?

- RESPONDENT 01
- FAMILY 02
- MEDICAL AID 03
- PROVIDED AT CLINIC OR PUBLIC HOSPITAL 04
- EMPLOYER 05
- OTHER _____ 96
(SPECIFY)

SECTION 7: HABITS AND LIFESTYLE

Now I would like to ask you a few questions about your diet and other habits.		
66	How old were you at your last birthday?	AGE IN COMPLETED YEARS <input type="text"/> <input type="text"/>
66a	Which race group do you consider yourself?	BLACK/AFRICAN 1 COLOURED 2 WHITE 3 ASIAN/INDIAN 4
67	Do you usually eat your food very salty, lightly salted or not salted?	VERY SALTY 1 LIGHTLY SALTED 2 NOT SALTED 3 DON'T KNOW 8
68	Do you usually add salt or Aromat/Fondor to your serving of food? IF YES, Before or after tasting the food?	NO, I NEVER ADD SALT/AROMAT 1 YES, BUT I TASTE FIRST AND THEN ADD . . 2 YES, EVEN BEFORE HAVING TASTED FOOD 3 DON'T KNOW 8
69	Do you eat salty snacks more often than three times per week (Such as chips, nikkaks, salted peanuts, salty biscuits, biltong, dried sausage, dried fish)?	YES 1 NO 2
70	Do you personally think that you are underweight, normal weight or overweight?	UNDERWEIGHT 1 NORMAL WEIGHT 2 OVERWEIGHT.. . . . 3 DON'T KNOW 8
71	Have you ever smoked tobacco, used snuff or chewed tobacco?	YES 1 NO 2
		→81
72	Have you ever smoked at least 100 cigarettes (5 packets of 20 cigarettes) or the equivalent amount of tobacco in your lifetime?	YES 1 NO 2
73	Have you ever smoked daily?	YES 1 NO 2
74	On average, what number of the following items do or did you smoke or use per day? PROBE AND FILL IN NUMBER FOR EACH ITEM.	MANUFACTURED CIGARETTES <input type="text"/> <input type="text"/> HAND-ROLLED CIGARETTES <input type="text"/> <input type="text"/> PIPEFULS OF TOBACCO <input type="text"/> <input type="text"/> CIGARS/CHEROOTS/CIGARILLOS <input type="text"/> <input type="text"/> SNUFF <input type="text"/> <input type="text"/> CHEWING TOBACCO/PRUIMPIE <input type="text"/> <input type="text"/>
75	CHECK 74: EVER SMOKED CIGARETTES, PIPES OR CIGARS <input type="text"/>	USES SNUFF OR CHEWING TOBACCO <input type="text"/> → 81
76	How many years have you smoked or did you smoke on a daily basis? (IF RESPONDENT HAS STOPPED AND STARTED AGAIN, ASK FOR TOTAL YEARS)	NUMBER OF YEARS <input type="text"/> <input type="text"/>

77	How old were you when you started smoking regularly?	AGE IN YEARS..... 	
78	Have you ever tried to quit smoking?	YES 1 NO 2	
79	Do you now smoke daily, occasionally or not at all?	DAILY 1 OCCASIONALLY 2 NOT AT ALL 3	→ 81
80	How long has it been since you last smoked daily?	LESS THAN (<)1 MONTH 01 1 MONTH TO < 6 MONTHS 02 6 MONTHS TO < 1 YEAR 03 1 YEAR TO < 5 YEARS 04 5 YEARS TO < 10 YEARS 05 10 YEARS OR MORE 06 NOT APPLICABLE 08	
81	Some people think that smoking is harmful to one's health; Other people think that smoking is good for your health; Some people think it does not matter to one's health whether one smokes or not. What do you think?	HARMFUL TO ONE'S HEALTH 1 GOOD FOR ONE'S HEALTH 2 DOES NOT MATTER 3	
82	Do you live in a house where other people smoke cigarettes regularly?	YES 1 NO 2	
83	Do you now work in a job where other people smoke cigarettes around you?	YES 1 NO 2 I DON'T WORK 8	
84	Have you ever worked in a job where you were regularly exposed to smoke, dust, fumes or strong smells?	YES 1 NO 2	→ 86
85	How long did you work in that job? IF LESS THAN 1 YEAR, WRITE '00'.	YEARS..... 	
86	Have you ever drunk alcohol?	YES 1 NO 2	→ anthro
87	Do you drink alcohol now?	YES 1 NO 2	→ 90
88	How much alcohol do you drink on average during the week?	NO DRINKING DURING THE WEEK 1 1-2 DRINKS PER DAY 2 3-4 DRINKS PER DAY 3 5 OR MORE DRINKS PER DAY 4 COMMUNAL DRINKING 5	
89	How much alcohol do you drink on average on weekends?	NO DRINKING DURING WEEKEND 1 1-2 DRINKS PER DAY 2 3-4 DRINKS PER DAY 3 5 OR MORE DRINKS PER DAY 4 COMMUNAL DRINKING 5	
90	Have you ever felt that you should cut down on your drinking?	YES 1 NO 2	
91	Have people annoyed you by criticizing your drinking?	YES 1 NO 2	
92	Have you ever felt bad or guilty about your drinking?	YES 1 NO 2	
93	Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?	YES 1 NO 2	

ADULT DEMOGRAPHIC AND HEALTH SURVEY
ANTHROPOMETRIC DATA SHEET

94	DATE	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="1"/>	<input type="text" value="9"/>	<input type="text"/>	<input type="text"/>
		d	d	m	m	y	y	y	y
95	FIELDWORKER NUMBER	<input type="text"/>	<input type="text"/>	<input type="text"/>					
96	WEIGHT (KG)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>				
97	HEIGHT (CM)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>				
98	MID-UPPER-ARM CIRCUMFERENCE (CM)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>				
99	WAIST CIRCUMFERENCE (CM)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>				
100	HIP CIRCUMFERENCE (CM)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>				
101	SYSTOLIC BLOOD PRESSURE 1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>				
102	DIASTOLIC BLOOD PRESSURE 1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>				
103	PULSE 1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>				
104	SYSTOLIC BLOOD PRESSURE 2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>				
105	DIASTOLIC BLOOD PRESSURE 2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>				
106	PULSE 2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>				
107	SYSTOLIC BLOOD PRESSURE 3	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>				
108	DIASTOLIC BLOOD PRESSURE 3	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>				
109	PULSE 3	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>				
110	PEAK EXPIRATORY FLOW RATE	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>				