APPENDIX QII: PATIENT/CONTROL QUESTIONAIRE
DRAFT
PERSONAL QUESTIONAIRE

Dear Madam,

You have recently been seen at the hospital for a gynecological visit. We are trying to find out the causes of several genital infections and other diseases in women and we would appreciate your co-operation in answering this brief questionnaire. We assure you that all information is strictly confidential and we wish to thank you for your participation.

NAME OF THE PATIENT/CONTROL

	Column Number	
	Patient Number	4-6
	Date of Interview / /	7-12
	Day /month /year	
1.	HOW OLD ARE YOU?	13-14
2.1	HAVE YOU EVER BEEN TO SCHOOL? YES… 1; NO …2 (If "yes" go to 2.2, if "no" go on to 3.1)	
2.2	How old were you when you finished your studies?	16-17
2.3	Which was the highest level of study completed? Primary 1 Secondary 2 Technical 3 University 4	18
3.1.1	Have you ever smoked(smoking is defined as at least 1 cigarette per day for at least 6months) Yes …1; No …2 (If "yes" go to 3.2, If "no" go on to 3.6)	19
3.2	At what age did you start smoking?	20-21
3.3	For how many years did you smoke?	22-23
3.4	On average, how much have you smoked? (Record the average number of cigarettes per day)	24-25
3.5	If you have quit, at what age did you quit?	26-27

3.6 Does your partner/partners smoke? Yes/No

3.7 Do you drink alcohol? Yes/No

If yes, at what age did you start drinking ?

What type of alcohol do you take?

Type of alcohol	**Quantity per day**	**Quantity per week**	**Quantity per month**
Beer			
Spirits			
Local *Waragi*			
Tonto			
Munansi			
Kwete			
Malwa			
Others specify			

Do you still drink alcohol ? Yes/No
If No, at what age did you quit?##

4.1 Have you ever been pregnant?
Yes… 1; No … 2 28
(If "yes" go to 4.2, if "no" go on to 5.1)

4.2 How old were you when your first child was born?

4.3 How many of the following have you had?
(Put 00 if none)

Full term pregnancies
Spontaneous abortions
Induced abortions

5.1 HAVE YOU HAVE EVER USED ANY OF THE BIRTH CONTROL METHODS AND FOR HOW LONG ?

Yes … 1; No … 2

	Yes/No (1or 2)	Duration (Years)
Oral Contraceptives		37-39
Condoms		40-42
Diaphragm		43-45
Tubal ligation		46-48
Foams, Creams		49-51
Other		52-54

*If less than 1year, code "01"

6.1 How old were you at first intercourse? 55-56

7.1 Approximately how many sexual partners have you had? 57

1 Partner	1
2-5 Partners	2
6-10 Partners	3
1-20 Partners	4
> 20 Partners	5

8.1 Have you ever had a veneral disease?

Yes … 1; No … 2; Don't know …9 58
(If "yes" go to 8.2, if no go on to 9.1)

8.2 WHICH DID YOU HAVE? (You may check more than one)

Yes … 1; No … 2; Don't know …9

Syphilis	59
Gonorrhea	60
Warts in the genital area	61
Herpes in the genital area	62
Other	63

Have you ever had lower abdomen pain associated with painful urination Yes/No?
If yes, how many times…
Have you ever had pus discharge from vagina? Yes/No
If Yes how many times…
Have you ever had genital ulcer Yes/No?
If yes how many times…

9.1 DURING YOUT LIFETIME, HOW MANY PAP SMEARS HAVE YOU HAD?

0-1Smears	1
2-5Smears	2
6-10Smears	3
11-15Smears	4
>15Smears	5
None	6
Don't know if ever had a PAP smear	9

9.2 HOW MANY YEARS AGO WAS YOUR LAST PAP SMEAR?

1year ago	1
2-3years ago	2
4-5years ago	3
5years ago	4
Don't know	9

10.2 During your lifetime, how frequently did you suffer from malaria per year?

Age	**Frequency**	**Do not remember/ Not sure**
0 – 10years		
11-19years		
20-29		
30-39		
40-49		
50-59		
60-69		
70+		

How frequent did you suffer from malaria during pregnancy?

	Frequency of attacks	**Do not remember/ Not sure**
1st Pregnancy		
2nd Pregnancy		
3rd Pregnancy		
4th Pregnancy		
5th Pregnancy		
6th Pregnancy		
7th Pregnancy		
8th Pregnancy		
Last Pregnancy		

10.3 In the last two years, how many attacks of malaria had you?

……

During your lifetime, how many places have you resided in?

……..

Give the names of places you have resided in the table below:-

Place of Residence	**Village**	**Sub-county**	**District**
1st			
2nd			
3rd			
4th			
5th			
6th			
7th			
8th			
Present			

11. What are sources of income for your family?
(a) Salary/wages (b) Business (c) family farming
(d) others specify ……

12. Are your family income adequate? (a) Yes (b) No

13. If No, how do you get additional income ?
……

14.1 What is your water supply ?
a) Tap water at home
b) Tap water in the neighborhood
c) Borehole
d) Spring/Pond
e) Stream/River/Lake

14.2 How far is the water supply.

Thank you very much for your time and effort

MEDICAL QUESTIONNAIRE FOR CONTROLS

Dear Doctor,
This form is to be completed for controls only. We greatly appreciate your cooperation.

NAME OF CONTROL:

DATE OF SAMPLING:

DESCRIBE THE MACROSCOPIC APPEARANCE OF THE CERVIX

Normal
Hyperaemic
Ulcerated
Purulent
Others (specify)

TYPES OF SAMPLES PROVIDED

Thin Prep
PAP Smear slides
Blood

GENERAL CONDITION OF CONTROL WOMAN

Anaemia Yes/No
Jaundice Yes/no
Wasting Nil/Mild/moderate/Severe

Abdominal Examination

Spleen: Palpable/Not palpable
If palpable, what is the size?

Any other organomegally