

S2 table

S2 Table: Response of *H. pylori* positive patients on first encounter

Sr. No	Questions	Possible responses
201	Have you ever diagnosed with H pylori infection before this?	<input type="checkbox"/> Yes (old) <input type="checkbox"/> No (New)
202	Have you taken triple therapy previously	<input type="checkbox"/> Yes <input type="checkbox"/> No
203	When your current health problem started?	<input type="checkbox"/> Since this week <input type="checkbox"/> Since last two weeks <input type="checkbox"/> Since a month <input type="checkbox"/> Since three months <input type="checkbox"/> Since six months <input type="checkbox"/> Since a year <input type="checkbox"/> Since two years <input type="checkbox"/> Before three years
204	Have you taken medications in the last two weeks?	<input type="checkbox"/> Yes (can you list _____) <input type="checkbox"/> No
205	When you feel discomfort/pain	<input type="checkbox"/> After meal <input type="checkbox"/> Before meal <input type="checkbox"/> Persistently or Always <input type="checkbox"/> At night
206	Which alcoholic drink(s) you had taken before you came for medical care? (more than one response)	<input type="checkbox"/> Traditional alcoholic drinks (Tella, Arekie, Teji) <input type="checkbox"/> Bears <input type="checkbox"/> Woin <input type="checkbox"/> Wuski <input type="checkbox"/> Others, specify _____
207	Do you have history of other chronic illnesses? (more than one response is possible)	<input type="checkbox"/> Liver disease <input type="checkbox"/> Kidney disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Hypertension

		<input type="checkbox"/> Asthma <input type="checkbox"/> Oher_____
208	Do you smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No
209	What traditional homemade remedies you took for the illness before you came here	_____ _____ _____
210	What modern medication other than the three drugs you took for the illness before you came here?	_____ _____ _____