



**UNIVERSIDADE FEDERAL DA BAHIA**

**FACULDADE DE FARMÁCIA**

Departamento de Análises Clínicas e Toxicológicas

Laboratório de Pesquisa em Parasitologia

Tel.: (71) 3283-6950; 3283-6954

ID: \_\_\_\_\_

Infirmery / Bed: \_\_\_\_\_

OS: \_\_\_\_\_

Height: \_\_\_\_ cm Weight: \_\_\_\_ Kg

pName: \_\_\_\_\_ Phone: \_\_\_\_\_

ID card \_\_\_\_\_ Healthy card (SUS): \_\_\_\_\_ Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Age: \_\_\_\_\_ Gender: ( ) M ( ) F Marital status: ( ) Single ( ) Married ( ) Civil union ( ) Others \_\_\_\_\_

Mother's name: \_\_\_\_\_

Address: \_\_\_\_\_

**- SOCIOECONOMIC AND SANITARY ASPECTS**

1. What is your education level?

- 1. ( ) None
- 2. ( ) Incomplete elementary school
- 3. ( ) Complete elementary school
- 4. ( ) Incomplete high school
- 5. ( ) Complete high school
- 6. ( ) University education

2. What is the total family income (per month)?

- 1. ( ) <1 minimum wage
- 2. ( ) 2 minimum wages
- 3. ( ) 3 minimum wages
- 4. ( ) 4 minimum wages
- 5. ( ) > 4 minimum wages

3. Where does the water for drinking and cooking come from?

- 1. ( ) Tap water
- 2. ( ) Well
- 3. ( ) Tank
- 4. ( ) River
- 5. ( ) Dam
- 6. ( ) Others \_\_\_\_\_

4. Boil or filter the water before drinking? ( ) Yes ( ) No ( ) Bottled water

5. Sanitary aspects:

- Is there sewage in the place where you live? ( ) Yes ( ) No
- Do you have bathroom with toilet? ( ) Yes ( ) No
- Do you have a cesspool? ( ) Yes ( ) No
- Is there a hand sink in the bathroom? ( ) Yes ( ) No
- Are the streets paved? ( ) Yes ( ) No

6. How is garbage collection done?

- ( ) All garbage is collected by the government
- 1. ( ) Daily
- 2. ( ) Weekly
- 3. ( ) None
- ( ) Other destinations
- 1. ( ) Trash is burnt
- 2. ( ) Garbage is accumulated in the streets
- 3. ( ) Garbage is accumulated in the yard

7. Do you walk barefoot? ( ) Yes ( ) No ( ) Sometimes

**- SIGNS OR SYMPTOMS AT HOSPITAL ADMISSION:**

1. Do you have any of the symptoms below?

- 1. ( ) Diarrhea
- 2. ( ) Intestinal constipation
- 3. ( ) Abdominal pain
- 4. ( ) Nausea
- 5. ( ) Vomiting
- 6. ( ) Breathing Problems
- 7. ( ) Others \_\_\_\_\_

**- SMOKE AND DRINK HABITS:**

1. Do you currently smoke tobacco? ( ) Yes ( ) No ( ) Former smoker

- If you are a smoker or ex-smoker, how long do/did you smoke? \_\_\_\_\_

2. How long have you been drinking alcohol? \_\_\_\_\_



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3. How often do you usually drink alcohol?

- Everyday                       1-4 times/week                       Only on weekends  
 1-3 times/month                       Less than once/month

4. What type of drink and how much do you usually consume per day?

- Beer \_\_\_\_\_                       Distilled \_\_\_\_\_                       Others \_\_\_\_\_

\*Please specify the type and number of drinks, type of glass used, and approximately the volume/quantity-per-glass, and if there is a day-to-day variation in drinking patterns.

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DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_      INTERVIEWER: \_\_\_\_\_      BLOOD COLLECTION TIME: \_\_\_\_\_