Clinical Examination Form Number: A ……

THE SOUTH AFRICAN NATIONAL HEALTH AND NUTRITION EXAMINATION SURVEY, 2011/2012

(SANHANES-1)

Adult Clinical Examination Form: 15 years and older

Examination Date	D	D	M	M	Y	Y	Y	Y

Time of arrival	H	H	:	M	M	**Time of departure**	H	H	:	M	M

PASTE APPOINTMENT CARD HERE

Final Response code	Full clinical examination completed and bloods collected ..... 1 Partial clinical examination completed and bloods collected ..... 2 Only full clinical examination completed ..... 3 Only partial clinical examination completed ..... 4 Bloods collected only 5

B. Examination Checklist			Completed		If No, Specify why not
Section A - F	Doctor	History and clinical examination	Y	N	
	Doctor	Fundoscopy – only for diabetic participants	Y	N	
	Doctor	Blood pressure and pulse rate	Y	N	
	Doctor	Cardiovascular Fitness (step test)	Y	N	
Section G	Clinic Assistant	Weight	Y	N	
	Clinic Assistant	Height	Y	N	
	Clinic Assistant	Mid upper arm circumference	Y	N	
	Clinic Assistant	Waist circumference	Y	N	
	Clinic Assistant	Hip circumference	Y	N	
	Clinic Assistant	Triceps Skinfold	Y	N	
	Clinic Assistant	Sub scapular Skinfold	Y	N	
	Clinic Assistant	Biceps Skinfold	Y	N	
	Clinic Assistant	Supra-iliac Skinfold	Y	N	
Section H - J	Nurse	Spirometry	Y	N	
	Nurse	Bioelectrical Impedance	Y	N	
	Nurse	Blood collection	Y	N	

Clinic Administrator	Name								
	Staff Number								

Doctor	Name								
	Staff Number								

Clinic Assistant	Name								
	Staff Number								

Nurse	Name								
	Staff Number								

INSTRUCTIONS	Sections A – F to be completed by the Doctor

Doctor	Start time	H	H	:	M	M

SECTION A — GENERAL PATIENT HISTORY (all participants)

I would like to ask you about your general health (circle as appropriate)

1	When was the last time you had something to eat?	Last night (before midnight) ..... 1 06:00 – 08:00 ..... 2 08:00 – 10:00 ..... 3 10:00 – 12:00 ..... 4 12:00 – 14:00 ..... 5 14:00 – 16:00 ..... 6 16:00 – 18:00 ..... 7 18:00 – 20:00 8
2	When was the last time you had something to drink?	Last night (before midnight) ..... 1 06:00 – 08:00 ..... 2 08:00 – 10:00 ..... 3 10:00 – 12:00 ..... 4 12:00 – 14:00 ..... 5 14:00 – 16:00 ..... 6 16:00 – 18:00 ..... 7 18:00 – 20:00 8
3	In your opinion, how would you describe your health today? **If completely healthy, go to Question 7**	Completely healthy ..... 1 Feeling unwell ..... 2 Don't know 3
4	How long have you not been feeling well or had this illness?	One day ..... 1 One week ..... 2 One month ..... 3 Longer 4
5	Do you have a fever today?	Yes ..... 1 No 2
6	Have you sought medical care for your illness or health problem? If yes, where have you gone for medical care? **Multiple responses possible**	Yes: GP / Private practitioner ..... 1 Yes: Clinic ..... 2 Yes: Day hospital ..... 3 Yes: Other public hospital ..... 4 Yes: Private hospital ..... 5 No 6
7	Do you have asthma?	Yes ..... 1 No 2
8	Do you have any past history of illness? If yes, what history of illness do you have? **Multiple responses possible**	Yes: ENT ..... 1 Yes: Heart ..... 2 Yes: Blood Sugar ..... 3 Yes: Chest ..... 4 Yes: Abdomen ..... 5 Yes: Cancer ..... 6 Yes: Other (specify) ..... 7 No 8

SECTION A	GENERAL PATIENT HISTORY (all participants)	
9	Is there a family history of illness? If yes, what illness runs in the family? **Multiple responses possible**	Yes: Heart ..... 1 Yes: Blood Sugar ..... 2 Yes: Chest ..... 3 Yes: Abdomen ..... 4 Yes: Cancer ..... 5 Yes: Other (specify) ..... 6 No 7
10	Have you had any past surgery? If yes, what surgery have you had? **Multiple responses possible**	Yes: ENT ..... 1 Yes: Heart ..... 2 Yes: Chest ..... 3 Yes: Abdomen ..... 4 Yes: Cancer ..... 5 Yes: Other (specify) ..... 6 No 7
11	Have you had any injuries? If yes, what type of injuries did you have? **Multiple responses possible**	Yes: Head ..... 1 Yes: Limbs ..... 2 Yes: Chest ..... 3 Yes: Abdomen ..... 4 No 5
12	Are you currently on any medication? If yes, what type of medication are you currently on? **Multiple responses possible**	Yes: Antibiotics ..... 1 Yes: Anti-inflammatory ..... 2 Yes: Pain ..... 3 Yes: Chest ..... 4 Yes: ENT ..... 5 Yes: Blood sugar ..... 6 Yes: Blood pressure ..... 7 Yes: Diuretics ..... 8 Yes: Heart disease ..... 9 Yes: Aspirin (daily) ..... 10 Yes: Antilipids ..... 11 Yes: Abdominal illness (diarrhoea or other) ..... 12 Yes: Depression ..... 13 Yes: Other mental illness ..... 14 Yes: Other (specify) ..... 15 No 16
13	Do you have any physical disabilities? **Multiple responses possible**	Yes: Impairment in mobility ..... 1 Yes: Spinal cord disability ..... 2 Yes: Brain disability ..... 3 Yes: Vision disability ..... 4 Yes: Hearing disability ..... 5 Yes: Cognitive disability ..... 6 Yes: Other (specify) ..... 7 No 8
14	Do you have any mental disabilities? **Multiple responses possible**	Yes: Mental disorder ..... 1 Yes: Neurological disorder ..... 2 Yes: Learning disability ..... 3 Yes: Mental retardation ..... 4 Yes: Other (specify) ..... 5 No 6

SECTION B — DETAILED PATIENT HISTORY: Over the past 3 months

(all participants)

1 GENERAL SYSTEMS (Over the past three months)

1.1	Have you lost weight without dieting?	Yes ..... 1 No 2
1.2	Have you gained weight?	Yes ..... 1 No 2
1.3	Has your appetite changed?	Yes: It has increased ..... 1 Yes: It has decreased ..... 2 No 3
1.4	Has your eating pattern changed?	Yes: He/she eats more frequently ..... 1 Yes: He/she eats less often ..... 2 No 3
1.5	Has your fluid intake changed?	Yes: It has increased ..... 1 Yes: It has decreased ..... 2 No 3
1.6	Have you been feeling thirsty more than usual?	Yes ..... 1 No 2
1.7	Did you have a fever?	Yes ..... 1 No 2
1.8	Have you felt tired / lethargic?	Yes ..... 1 No 2
1.9	Did you have night sweats?	Yes ..... 1 No 2

2 HEAD, EYES, EARS, NOSE, MOUTH AND THROAT (Over the past three months)

2.1	Have you had any headaches?	Yes: Migraine ..... 1 Yes: Tension ..... 2 Yes: Cluster ..... 3 Yes: Other (specify) ..... 4 No 5
2.2	Have you had repeated episodes of dizziness?	Yes ..... 1 No 2
2.3	Have you had a seizure? **Multiple responses possible**	Yes: Grand mal ..... 1 Yes: Petit mal ..... 2 Yes: Other (specify) ..... 3 No 4
2.4	Have you had any head trauma?	Yes ..... 1 No 2
2.5	Have you had any of the following eye problems? **Multiple responses possible**	Yes: Difficulties in seeing things ..... 1 Yes: Cannot see at night ..... 2 Yes: Cannot see from the sides of your eyes ..... 3 Yes: Discharge (yellow) ..... 4 Yes: Discharge (watery) ..... 5 Yes: Discharge (other) ..... 6 Yes: Other (specify) ..... 7 No 8

SECTION B	DETAILED PATIENT HISTORY: Over the past 3 months (all participants)	
2.6	Have you had any of the following ear problems? **Multiple responses possible**	Yes: Ear pain ..... 1 Yes: Ringing in the ears ..... 2 Yes: Feels like the room is spinning ..... 3 Yes: Discharge (yellow) ..... 4 Yes: Discharge (watery) ..... 5 Yes: Discharge (bloody) ..... 6 Yes: Discharge (other) ..... 7 Yes: Other (specify) ..... 8 No 9
2.7	Have you had any of the following nose problems? **Multiple responses possible**	Yes: Nose bleeds ..... 1 Yes: Discharge ..... 2 Yes: Sinus ..... 3 Yes: Other (specify) ..... 4 No 5
2.8	Have you had any of the following mouth problems? **Multiple responses possible**	Yes: Sore throat ..... 1 Yes: Toothache ..... 2 Yes: Pain in the mouth or gums ..... 3 Yes: Other (specify) ..... 4 No 5

3 RESPIRATORY SYSTEM (Over the past three months)

3.1	Have you had any difficulty in breathing / shortness of breath? If yes, what kind of difficulty did you have in breathing? **Multiple responses possible**	Yes: Worse at night ..... 1 Yes: Wheezing ..... 2 Yes: Stridor ..... 3 Yes: Other (specify) ..... 4 No 5
3.2	Did you have a cough?	Yes ..... 1 No 2
3.3	If yes, please specify the type of cough?	Dry ..... 1 Wet ..... 2 Other (specify) ..... 3 .....
3.4	If yes, please specify the colour of the sputum?	White ..... 1 Yellow ..... 2 Green ..... 3 Blood ..... 4 Other (specify) ..... 5 .....
3.5	Were you in contact with a person that coughs a lot?	Yes ..... 1 No 2
3.6	Did you have an asthma attack?	Yes ..... 1 No 2

4 CARDIOVASCULAR SYSTEM (Over the past three months)

4.1	Did you have any chest pain?	Yes ..... 1 No 2
4.2	Did you have shortness of breath when lying down?	Yes ..... 1 No 2

4.3	Did you have swelling of any of the following?	Yes: Hands ..... 1 Yes: Feet ..... 2 Yes: Both hands and feet ..... 3 Yes: Other (specify) ..... 4 No 5

5 GASTRO-INTESTINAL SYSTEM (Over the past three months)

5.1	Did you have any of the following tummy problems? **Multiple responses possible**	Yes: Pain in the stomach ..... 1 Yes: Nausea ..... 2 Yes: Vomiting ..... 3 Yes: Diarrhoea ..... 4 Yes: Constipation ..... 5 Yes: Bloody stools ..... 6 Yes: Yellowing (discolouration) of the eyes ..... 7 Yes: Problem eating or swallowing ..... 8 Yes: Other (specify) ..... 9 No 10

6 GENITO-URINARY SYSTEM (Over the past three months)

6.1	Did you pass urine more than usual?	Yes ..... 1 No 2
6.2	Did you have pain when passing urine?	Yes ..... 1 No 2
6.3	Did you have blood in the urine?	Yes ..... 1 No 2
6.4	Did the colour of your urine differ from what it usually is?	Yes ..... 1 No 2
6.5	Did you experience any of the following? **Multiple responses possible** **FOR MEN ONLY**	Yes: Reduced force when passing urine ..... 1 Yes: Hesitancy to pass urine ..... 2 Yes: Dribble when passing urine ..... 3 Yes: Other (specify) ..... 4 No 5

7 SEXUAL AND REPRODUCTIVE SYSTEM (Over the past three months)

7.1	Did you have any of the following problems? **Multiple responses possible** **FOR MEN ONLY**	Yes: Urethral discharge "drops" ..... 1 Yes: Groin swelling ..... 2 Yes: Testicular swelling ..... 3 Yes: Other (specify) ..... 4 No 5
7.2	Did you have any of the following problems? **Multiple responses possible** **FOR WOMEN ONLY**	Yes: Vaginal discharge ..... 1 Yes: Vaginal bleeding (other than menstruation) ..... 2 Yes: Other (specify) ..... 3 No 4
7.3	When was the last time you had a pap smear? **FOR WOMEN ONLY**	0 – 6 months ago ..... 1 6 – 12 months ago ..... 2 1 – 2 years ..... 3 2 – 4 years ago ..... 4 5 –10 years ago ..... 5 More than 10 years ago ..... 6 Never 7

SECTION B — DETAILED PATIENT HISTORY: Over the past 3 months (all participants)

8 SKIN AND LYMPH NODES (Over the past three months)

8.1	Did you have any of the following skin problems? **Multiple responses possible**	Yes: Skin rashes (local) ..... 1 Yes: Skin rashes (generalised) ..... 2 Yes: Skin rashes (itchy) ..... 3 Yes: Bruises ..... 4 Yes: Skin discolouration ..... 5 Yes: Other (specify) ..... 6 No 7
8.2	Did you have any swollen glands? If yes, which of your glands were swollen? **Multiple responses possible**	Yes: Neck ..... 1 Yes: Axilla ..... 2 Yes: Epitrochlear ..... 3 Yes: Other (specify) ..... 4 No 5

9 MUSCULOSKELETAL DISORDERS (Over the past three months)

9.1	Did you have any of the following muscle / bone problems? **Multiple responses possible**	Yes: Pain in the joints ..... 1 Yes: Swelling in the joints ..... 2 Yes: Arthritis ..... 3 Yes: Muscle pain ..... 4 Yes: Other (specify) ..... 5 No 6

SECTION C — SYSTEMATIC CLINICAL EXAMINATION (all participants)

1 GENERAL SYSTEMS

1.1	Pallor	Yes ..... 1 No 2
1.2	Rash **Multiple responses possible**	Yes: Scratch marks ..... 1 Yes: Erythematous ..... 2 Yes: Blanching on pressure ..... 3 Yes: Purpuric ..... 4 Yes: Macules ..... 5 Yes: Papules ..... 6 Yes: Vesicles ..... 7 Yes: Impetigo ..... 8 No 9
1.3	Jaundice	Yes ..... 1 No 2
1.4	Central cyanosis	Yes ..... 1 No 2
1.5	Peripheral cyanosis	Yes ..... 1 No 2
1.6	Finger clubbing	Yes ..... 1 No 2
1.7	General oedema	Yes ..... 1 No 2
1.8	Peripheral oedema	Yes ..... 1 No 2

SECTION C	SYSTEMATIC CLINICAL EXAMINATION (all participants)	
1.9	Lymphadenopathy If yes, please specify the position **Multiple responses possible**	Yes: Neck ..... 1 Yes: Axilla ..... 2 Yes: Epitrochlear ..... 3 No 4
1.10	Hydration If dehydrated, specify the grade / symptoms **Multiple responses possible**	Normal ..... 1 **Dehydrated (mild-moderate)** Restlessness / irritability ..... 2 Sunken eyes ..... 3 Headache ..... 4 Decreased urine output ..... 5 Skin turgor <2 seconds ..... 6 **Dehydrated (severe)** Sleepy/lethargic ..... 7 Sunken eyes ..... 8 Dizziness or light-headedness ..... 9 Skin turgor >2 seconds 10
1.11	Dysmorphism	Yes ..... 1 No 2
1.12	Hearing	Normal ..... 1 Loss of hearing 2
1.13	If loss of hearing, record which of the following are present **Multiple responses possible**	Inability to hear people clearly and fully ..... 1 Frequent requests for repetition or clarification ..... 2 Tendency to bluff ..... 3 Tendency to lip read ..... 4 None 5
1.14	Vision	Normal ..... 1 Loss of vision 2
1.15	If loss of vision, record which of the following are present **Multiple responses possible**	Blurred vision ..... 1 Need for more light ..... 2 Gradual loss of peripheral, or side, vision ..... 3 Difficulty driving at night ..... 4 Double vision ..... 5 Difficulty in reading ..... 6 Difficulty in distinguishing colours ..... 7 Straight lines look wavy ..... 8 Sensitivity to glare 9
1.16	Fundoscopy: Macula **Only for diabetics** **Multiple responses possible**	Normal ..... 1 Abnormal: Oedema ..... 2 Abnormal: Lipid deposition ..... 3 Abnormal: Capillary obliteration ..... 4 Abnormal: Other (specify) ..... 5 .....
1.17	Fundoscopy: Retina **Only for diabetics** **Multiple responses possible**	Normal ..... 1 Abnormal: Microaneurisms ..... 2 Abnormal: Intra retinal haemorrhages ..... 3 Abnormal: Exudates ..... 4 Abnormal: Neovascularisation ..... 5 Abnormal: Vitreous haemorrhage ..... 6 Abnormal: Other (specify) ..... 7 .....

SECTION C SYSTEMATIC CLINICAL EXAMINATION (all participants)

2 EARS, NOSE AND THROAT

2.1	Mouth sores	Yes ..... 1 No 2
2.2	Nasal Discharge If yes, specify the type of discharge **Multiple responses possible**	Yes: Yellow ..... 1 Yes: Watery ..... 2 Yes: Bloody ..... 3 Yes: Other ..... 4 No 5
2.3	Swollen tonsils	Yes ..... 1 No 2
2.4	Ears **Multiple responses possible**	Normal ..... 1 Infection ..... 2 No 3

3 RESPIRATORY SYSTEM

3.1	Nasal flare	Yes ..... 1 No 2
3.2	Chest shape **Multiple responses possible**	Normal ..... 1 Pectus carinatum ..... 2 Pectus excavatum ..... 3 Scoliosis ..... 4 Kyphosis ..... 5 Gynecomastia (male) ..... 6 Barrel chest deformity 7
3.3	Rib retraction	Yes ..... 1 No 2
3.4	Tachypnoea	Yes: >10 years: >20/min ..... 1 No 2
3.5	Cyanosis	Yes: Central ..... 1 Yes: Peripheral ..... 2 No 3
3.6	Trachea displacement	Yes ..... 1 No 2
3.7	Percussion	Normal ..... 1 Abnormal: Consolidation ..... 2 Abnormal: Pleural effusion 3
3.8	Auscultation **Multiple responses possible**	Normal ..... 1 Abnormal: Unequal bilateral air entry ..... 2 Abnormal: Crepitations ..... 3 Abnormal: Rhonchi ..... 4 Abnormal: Wheezing ..... 5 Abnormal: Consolidation (Bronchial Breathing) 6

4 CARDIOVASCULAR SYSTEM

4.1	Apex **Multiple responses possible**	Normal ..... 1 Visible pulsations ..... 2 Displaced 3
4.2	Pulse **Record Pulse in Section E**	Normal ..... 1 *> 10 Years: 60-100/min* Tachycardia 2

4.3	Auscultation: Heart sounds **Multiple responses possible**	Normal ..... 1 Abnormal: Systolic Grade I ..... 2 Abnormal: Systolic Grade II ..... 3 Abnormal: Systolic Grade III ..... 4 Abnormal: Systolic Grade IV ..... 5 Abnormal: Diastolic Grade I ..... 6 Abnormal: Diastolic Grade II ..... 7 Abnormal: Diastolic Grade III ..... 8 Abnormal: Diastolic Grade IV 9
4.4	Auscultation: Arrhythmia	Yes: Tachyarrhythmia ..... 1 Yes: Bradyarrhythmia ..... 2 Yes: Atrial Fibrillation ..... 3 No 4

5 GASTRO-INTESTINAL SYSTEM

5.1	Distension	Yes ..... 1 No 2
5.2	Tenderness If yes, specify location **Multiple responses possible**	Yes: Upper central ..... 1 Yes: Lower central ..... 2 Yes: Left hypochondrium ..... 3 Yes: Right hypochondrium ..... 4 Yes: Left inguinal ..... 5 Yes: Right inguinal ..... 6 Yes: Left flank ..... 7 Yes: Right flank ..... 8 Yes: Suprapubic ..... 9 No 10
5.3	Abdominal mass If yes, specify location **Multiple responses possible**	Yes: Upper central ..... 1 Yes: Lower central ..... 2 Yes: Left hypochondrium ..... 3 Yes: Right hypochondrium ..... 4 Yes: Left inguinal ..... 5 Yes: Right inguinal ..... 6 Yes: Left flank ..... 7 Yes: Right flank ..... 8 Yes: Suprapubic ..... 9 No 10
5.4	Organomegaly	Yes: Hepatomegaly ..... 1 Yes: Splenomegaly ..... 2 No 3
5.5	Renal mass	Yes ..... 1 No 2
5.6	Hernias	Yes ..... 1 No 2
5.7	Bowel sounds	Normal ..... 1 Absent ..... 2 Accentuated 3

SECTION C SYSTEMATIC CLINICAL EXAMINATION (all participants)

6 CENTRAL NERVOUS SYSTEM

6.1	Face, Head shape, neck If abnormal, specify which of the following are present **Multiple responses possible**	Normal ..... 1 Abnormal: Facial tics ..... 2 Abnormal: Bell's palsy ..... 3 Abnormal: Padget's disease ..... 4 Abnormal: Acromegaly ..... 5 Abnormal: Cervical arthritis ..... 6 Abnormal: Thyroid 7
6.2	Motor function: gait If abnormal, specify which of the following are present **Multiple responses possible**	Normal ..... 1 Abnormal: Ataxia ..... 2 Abnormal: Spasticity ..... 3 Abnormal: Staggering 4
6.3	Motor function: movements If abnormal, specify which of the following are present **Multiple responses possible**	Normal ..... 1 Abnormal: Unable to sit/stand ..... 2 Abnormal: Tremor ..... 3 Abnormal: Tics ..... 4 Abnormal: Rolling eye movements 5
6.4	Motor function: tone If abnormal, specify which of the following are present **Multiple responses possible**	Normal ..... 1 Abnormal: Hypotonia ..... 2 Abnormal: Hypertonia ..... 3 Abnormal: Limited movements ..... 4 Abnormal: Uncontrolled movements ..... 5 Abnormal: Brudzinski's sign 6
6.5	Motor function: coordination If abnormal, specify which of the following are present **Multiple responses possible**	Normal ..... 1 Abnormal: Change in walking ..... 2 Abnormal: Dropping things more than usual ..... 3 Abnormal: Spilling fluids more than usual 4
6.6	Level of consciousness If abnormal, specify which of the following are present **Multiple responses possible**	Normal ..... 1 Abnormal: Hyperexcitability ..... 2 Abnormal: Unresponsiveness ..... 3 Abnormal: Drowsiness ..... 4 Abnormal: Semi-conscious ..... 5 Abnormal: Unconscious 6

7 MUSCULO-SKELETAL SYSTEM

7.1	Muscle weakness	Yes ..... 1 No 2
7.2	Bone swellings **Multiple responses possible**	Yes: Long bones and joints ..... 1 Yes: Ribs ..... 2 Yes: Spine ..... 3 Yes: Skull ..... 4 No 5

SECTION D — Referral (identified participants)

PROVISIONAL DIAGNOSIS

Clinical impression/ provisional diagnosis					
Referral to (please tick)	GP / Private Practitioner	Clinic	Day hospital	Other public hospital	Private hospital
Referral letter given	Yes ..... 1 No 2				

SECTION E — Blood pressure and pulse rate (participants 8yrs and older)

	Measurement type	Recorded measurements	Final Blood Pressure
1	Systolic (mmHg)	1 ☐☐☐ 2 ☐☐☐ 3 ☐☐☐	4 ☐☐☐
2	Diastolic (mmHg)	1 ☐☐☐ 2 ☐☐☐ 3 ☐☐☐	4 ☐☐☐
3	**PULSE RATE** (bpm)	1 ☐☐☐ 2 ☐☐☐ 3 ☐☐☐	4 ☐☐☐

SECTION F — Step fitness test (participants aged 18-40 years)

Note: *Participants can be excluded from this test on clinical grounds.*

1	Was the step test performed?	Yes ..... 1 No 2
2	If the test was not done, specify the reason	Cardiac ..... 1 Respiratory ..... 2 Other ..... 3 .....
3	AGE	☐☐
4	MAX PULSE RATE FOR AGE **(from the table)**	☐☐☐
5	**PULSE RATE** (bpm)	☐☐☐
6	Systolic (mmHg) **(POST EXERCISE)**	☐☐☐
7	Diastolic (mmHg) **(POST EXERCISE)**	☐☐☐

Doctor	**End time**	H H : M M

INSTRUCTIONS	Section G to be completed by the Clinic Assistant

Clinic Assistant	Start time	H H : M M

SECTION G — Anthropometry

	Measurement type	Unit	Recorded measurements		
1	**Weight** (all participants)	**kg**	1 , 2 , 3 ,	4 , 5 ,	**Unable to obtain a measurement**
2	**Height** (all participants)	**cm**	1 , 2 , 3 ,	4 , 5 ,	**Unable to obtain a measurement**
3	**Mid upper arm circumference** (3 months and older)	**cm**	1 , 2 , 3 ,	4 , 5 ,	**Unable to obtain a measurement**
4	**Triceps Skinfold** (3 months and older)	**cm**	1 , 2 , 3 ,	4 , 5 ,	**Unable to obtain a measurement**
5	**Sub scapular Skinfold** (3 months and older)	**cm**	1 , 2 , 3 ,	4 , 5 ,	**Unable to obtain a measurement**
6	**Biceps Skinfold** (18 years and older)	**cm**	1 , 2 , 3 ,	4 , 5 ,	**Unable to obtain a measurement**
7	**Supra-iliac Skinfold** (18 years and older)	**cm**	1 , 2 , 3 ,	4 , 5 ,	**Unable to obtain a measurement**
8	**Waist circumference** (3 months and older)	**cm**	1 , 2 , 3 ,	4 , 5 ,	**Unable to obtain a measurement**
9	**Hip circumference** (3 months and older)	**cm**	1 , 2 , 3 ,	4 , 5 ,	**Unable to obtain a measurement**

Clinic Assistant	End time	H H : M M

INSTRUCTIONS	Sections H – J to be completed by the Nurse

Nurse	Start time	H H : M M

SECTION H — Spirometry (18 yrs and older)

Note: *Participants can be excluded from this test on clinical grounds (eg. asthma)*

1	Was the spirometry test performed?	Yes ..... 1 No 2
2	If the test was not done, specify the reason	Asthma ..... 1 Other (specify) ..... 2 .....

Please record the following:

Temperature (^{o}C) ☐☐.☐ ***Humidity(%)*** ☐☐ ***Pressure (hPa)*** ☐☐☐☐

	Measurement	Units	Recorded measurements	Final Measurement
3	**Forced vital capacity (FVC)**	**L**	1 ☐☐,☐☐☐ 2 ☐☐,☐☐☐ 3 ☐☐,☐☐☐	4 ☐☐,☐☐☐
4	**Forced expiratory volume (FEV-1)**	**L**	1 ☐☐,☐☐☐ 2 ☐☐,☐☐☐ 3 ☐☐,☐☐☐	4 ☐☐,☐☐☐
5	**FEV-1/FVC ratio**	**L**	1 ☐☐,☐☐☐ 2 ☐☐,☐☐☐ 3 ☐☐,☐☐☐	4 ☐☐,☐☐☐
6	**Forced expiratory flow 25-75% (FEF 25-75)**	**L**	1 ☐☐,☐☐☐ 2 ☐☐,☐☐☐ 3 ☐☐,☐☐☐	4 ☐☐,☐☐☐

SECTION I — Bioelectrical impedance (18 yrs and older)

Note: *Participants can be excluded from this test on clinical grounds*

Note: *Variations in body composition may occur in patients pre-menstrually, during menstruation, with renal failure, on some prescription medications (particularly Diuretics) and other conditions causing water retention or water loss*

1	Was the bioelectrical impedance test performed?	Yes ..... 1 No 2
2	If the test was not done, specify the reason	Pace maker ..... 1 Artificial limbs/joints ..... 2 Hearing aid ..... 3 Diuretics ..... 4 Alcohol consumed ..... 5 Full bladder 6

	Measurement		Recorded measurements	Final Measurement
3	**Z-ohm value**	**ohms**	1 ☐☐☐☐,☐ 2 ☐☐☐☐,☐ 3 ☐☐☐☐,☐	4 ☐☐☐☐,☐

SECTION J	Blood collection		
No.	**Biomarkers**	**Respondent category (age)**	**Specimen Collected**
1	Full blood count	2 years and older	Yes.....1 No .....2 Missing value – failure to collect a specimen 3
2	Cholesterol (total)	6 years and older	Yes.....1 No .....2 Missing value – failure to collect a specimen 3
3	HDL	6 years and older	Yes.....1 No .....2 Missing value – failure to collect a specimen 3
4	LDL	6 years and older	Yes.....1 No .....2 Missing value – failure to collect a specimen 3
5	Triglycerides	6 years and older	Yes.....1 No .....2 Missing value – failure to collect a specimen 3
6	Glucose (plasma)	6 years and older	Yes.....1 No .....2 Missing value – failure to collect a specimen 3
7	C-reactive protein	6 years and older	Yes.....1 No .....2 Missing value – failure to collect a specimen 3
8	Cotinine	10 years and older	Yes.....1 No .....2 Missing value – failure to collect a specimen 3
9	Zinc status	0 – 5 years, and women 16 – 35 years	Yes.....1 No .....2 Missing value – failure to collect a specimen 3
10	Vitamin A status	0 – 5 years, and women 16 – 35 years	Yes.....1 No .....2 Missing value – failure to collect a specimen 3
11	Iron status	0 – 5 years, and women 16 – 35 years	Yes.....1 No .....2 Missing value – failure to collect a specimen 3

Nurse	**End time**	H	H	:	M	M