Client Name (cut off at dotted line after data entry):_____

.....

CASE GROUP Study Questionnaire: Risk factors for Pre-Eclampsia/Eclampsia, PCMH

Hospital registration Number _____

Date of interview_____

Study ID_____

Staff name_____

I. Sociodemographic/economic information

1. **Client age (years):** _____
2. **Religion:** Christian □ Muslim □ Other □**:** _____
3. **Ethnicity:** Mende □ Temne □ Limba □ Fullah □ Krio □ Other □**:** _____
4. **Marital status**: Married □ Cohabit □ Single □ Widowed □ Divorced □
5. **Completed education:** None □ Primary □ Secondary □ Tertiary □
6. **Occupation:** Housewife □ Farmer □ Trader/Seller □ Student □ Other □**:**_____
7. **Income in SLL per month :** _____ SLL
8. **Place of residence:** city □ suburb □ rural □
9. **Travel Time to Hospital(PCMH)**(min): _____**Travel cost to the hospital** (SLL) :_____
10. **No. of children living at your home you take care of and age?**
    a. Own children (number and age)_____
    b. Other children (number and age) _____
11. **Is there any pollution in your environment of daily living, e.g. working environment or home?**
    Yes (at least one mark below) □ No □ Don´t know □

Close to waste deposit □ Close to main road □ Cooking with open fire in closed room □
Working with chemicals (e.g. pesticides, paint, car components) □ Close to oil refinery □
Other sources of pollution □: _____

12. **Is the following present in your household:**

Electricity: Yes □ No □ Pipe-borne water: Yes □ No □ Mobile phone: Yes □ No □
Radio: Yes □ No □ TV: Yes □ No □ Fridge: Yes □ No □
Cattle: Yes □ No □ Motor-bike, Car: Yes □ No □ Mosquito- net: Yes □ No □

13. **Main origin of drinking water:**

Bottled water □ Other packaged water □ Boiled pipe-borne water □ Unboiled pipe-borne water □
Boiled well water □ Unboiled well water □ Boiled bore whole water □ Unboiled bore whole water □
Other source □:_____

II. Recruitment information

1. **Client was recruited in:** ANC □ OPD □ Triage □ Ward2 □ Ward3 □ Ward4 □ Ward5 □ Ward6 □
   a. If recruited in OPD or Triage, please state reason for hospital visit:_____
   b. If recruited in ANC, visit no.: _____
2. **If client is still pregnant**: Gestational week: _____
3. **If client has already delivered:** Date of delivery:_____
4. **Diagnosis of:** Preeclampsia □ Eclampsia □
   a.Specify Date of Diagnosis:_____

Client Name (cut off at dotted line after data entry):_____
.....

5. **a. Blood pressure at diagnosis:**_____
   b. Repeat measure after: _____hrs., blood pressure: _____
6. **Proteinuria grade** _____
7. **Seizure present:** Yes □ No □ Don´t know □
8. **Any Doubts about correctness of Diagnosis, if yes specify:**
   _____
9. **Reported PE/E Symptoms of client:** asymptomatic □, or any of the following:
   Headache □ Epigastric pain □ Vomiting □ Nausea □ Blurred vision □ Oedema □
   Other symptoms: _____
10. **PE/E treatment:** MgSO4 □ Hydralazine □ Nifedipine(Adalat) □ Methyldopa(Aldomet) □
    Other treatment for PE/E □ : _____

III. Information in the case of client´s death

1. **In case of reported death of client in study period, state date of death:** _____

Specify, a. Cause of death: _____
b. Treatment: _____
c .Complications: _____

IV. Information in the case of delivery

1. **Baby is:** live birth □ fresh stillbirth □ macerated stillbirth □ neonatal death □
   a. If stillbirth or neonatal death reason known?_____
2. **Sex:** Female□ Male□
3. **Gestational week at delivery:** _____
   a. Preterm birth <37GW □
4. **Delivery mode:** Spontaneous vaginal □ Operation vaginal □ Planned CS □ Emergency CS □
5. **Apgar score(s)**: _____
6. **Birth weight:** _____g
7. **Visible birth defects**? Yes □ No □ Don´t know □
   If yes, specify: _____
8. **Neonatal complications?** Yes □ No □ Don´t know □
   If yes, specify: _____

V. Pregnancy-related health information

1. **Current maternal weight:** _____kg, as of (date)_____
2. **Visual evidence of overweight:** Yes □ No □ Don´t know □
3. **MUAC (mid upper arm circumference):** _____cm
4. **No. of all your pregnancies (including this one):** _____
5. **Time interval to last pregnancy: months between dates of birth (or expected Date of Birth):**
   _____
6. **Have you ever experienced an abortion/miscarriage/stillbirth** Yes □ No □ Don´t know □
   a. If yes, how many? _____
   b. when (which year) _____
   c. If known, gestational week:_____
   d. If known, state reason: _____

Client Name (cut off at dotted line after data entry):_____

7. **Did you ever have an induced abortion?** Yes □ No □ **If yes,** which year(s)? _____
8. **Current pregnancy a twin gestation?** Yes □ No □ Other (triplets) □_____
9. **No. pregnancies with same partner of the current pregnancy:** Don´t know□
   First pregnancy with this partner□ Have one or more pregnancies with that partner already□
10. **Did you experience PE/E in a previous pregnancy?** Yes □ No □ Don´t know □
    a. If yes, which year(s) _____
    b. If yes, specify treatment_____
    c. If yes, specify outcomes:_____
11. **Known cases of PE/E in any other family member** (JUST Family related by blood) **?**
    Yes □ No □ Don´t know □
    a. If yes, specify who: Mother □ Aunt □ Sister □ Other □ _____
    b. If yes, specify when: _____

12. **Did you experience one of the following during THIS pregnancy**?
    Diarrhea (>2 weeks): Yes □ No □ Don't know □
    Urinary tract infection: Yes □ No □ Don't know □
    Anaemia: Yes □ No □ Don't know □
    Gestational diabetes: Yes □ No □ Don't know □
    Placenta praevia: Yes □ No □ Don't know □
    STI/vaginal discharge : Yes □ No □ Don't know □
    b. Specify any other medical condition or persistent complaint (what, when, treatment):
    _____
    _____

13. **Any Malaria episode during this pregnancy?** Yes □ No □ Don´t know □
    If yes, reported Malaria Symptoms of client: asymptomatic □, or any of the following:

    Fever □ Chills/Shivering □ Headache □ Vomiting □ Sweats □ Diarrhea □ Jaundice □
    Other symptoms: _____
    If yes, was diagnosis: symptom-based only □ lab-confirmed □ Don´t know □
    If yes GW/Month of Pregnancy of Malariaepisode(s) : _____GW(s)/Month(s)
    If yes did you receive IPTp before this Malariaepisode(s) occured: Yes□ No□ Don´t know□
    If yes was there any Treatment? Yes □ No □ Don´t know □
    If yes, specify Treatment: _____

14. **Total number of ANC visits during this pregnancy**: _____

15. **Regular (at least 2 Doses) intake of IPTp (Fansidar)?** Yes □ No □ Don´t know □
    If yes, specify how many Doses (1 Dose = 3 Pills) of IPTp (Fansidar) did you take?
    1Dose □ 2Doses □ 3Doses□ >3 Doses □ specify how many :_____
    If yes, specify when did you take IPTp (Fansidar) during pregnancy?
    GW/Month of 1. Dose: _____ GW/Month
    GW/Month of 2. Dose: _____ GW/Month
    GW/Month of 3. Dose: _____ GW/Month
    GW/Month of 4.Dose: _____ GW/Month

Client Name (cut off at dotted line after data entry):_____

16. **Do you sleep under a Mosquito-net?** Yes □ No □ Don´t know □
If yes, how often did you sleep under a Mosquito-net <u>during this Pregnancy</u>?
never □ sometimes □ often □ daily □
Is the Mosquito-net treated with insecticide? Yes □ No □ Don´t know □
17. **Use of insect repellents indoor?** never□ sometimes □ often □ always □
a.Specify which kind of repellent: _____

18. **Did you experience ANY fever episode during this pregnancy?** Yes □ No □ Don´t know □
19. **Frequent** (≥**3 times a week) heavy physical work during pregnancy:** Yes □ No □
a. If yes: carry heavy weights □ farm work □ long distance walking (≥2 hours per day) □ prolonged standing(≥6 hours per day)□ manual laundry □ carry heavy weights on head □ other physical work:_____
20. **Average sleep duration:** ≥6 hours per night □ 3-6 hours per night □ <3 hours per night □
a. Sleeping quality during this pregnancy:
daytime sleepiness □ snoring □ sleep-disordered breathing □ frequently waking up at night □

VI. <u>General health and behavior-related information</u>

1. **History of chronic Hypertension:** Yes □ No □ Don´t know □
a. If yes since (year) _____
b. If yes last measured blood pressure: _____ mmHg

2. **History of Diabetes** Yes □ No □ Don´t know □
a. If yes since (year) _____
b. If yes which Type? Type I □ Type II □ Don´t know □

3. **List all medical diagnoses you have or persistent complaints received during the <u>PAST YEAR</u> and treatments**: _____
_____
a. Visit of traditional healer? never □ sometimes □ often □
b. Use of any traditional treatments? never □ sometimes □ often □
If yes, please specify Herbs and Diagnosis you received <u>during THIS Pregnancy:</u>
_____
_____

4. **Family history of chronic Hypertension:** Yes □ No □ Don´t know □
a. If yes, specify who (JUST Family related by blood): Mother□ Father□ Sibling□ Other□

5. **Family history of Diabetes:** Yes □ No □ Don´t know □
a. If yes, specify who (JUST family related by blood): Mother□ Father□ Sibling□ Other□

6. **Do you smoke or used to smoke?** Yes □ No, never smoked □ Used to smoke, but quit □
a. If yes, how many cigarettes per day /since when/ until when? _____
_____

Client Name (cut off at dotted line after data entry):_____

7. **Do you drink alcohol or used to drink alcohol?** Yes □ No, never □ Used to drink alcohol □
   a. If yes, how much per week/since when?_____
   b. If yes, how much during this pregnancy?_____

8. **Describe what you ate the last day at home BEFORE you came to the hospital (ALL MEALS!):**_____
   _____
   _____

9. **Daily diet you eat every day includes calcium sources?**
   Yes, at least one (mark below) □ None □ Don´t know □
   Milk/dairy products □ Fish with bones □ Beans/Peas □ Groundnuts □
   Dark green leaves □ Calcium-supplemented food/juice □ Calcium Pills □ Other □

10. **General fruit intake:** never □ monthly □ every 2 weeks □ weekly □ daily □

11. **General vegetable intake:** never □ monthly □ every 2 weeks □ weekly □ daily □

12. **General meat intake:** never □ monthly □ every 2 weeks □ weekly □ daily □

13. **General animal products intake:** never □ monthly □ every 2 weeks □ weekly□ daily □
    (e.g. cheese, milk, egg NO meat)

14. **Do you feel you have a lot of emotional stress in general?** Yes □ No □ Don´t know □
    a. If yes, specify reasons: money problems□ personal conflicts□ domestic violence□
    family conflicts □ death □ Other reasons□:_____
    _____
    Describe common stressful events: _____
    Frequency of such stressful events: <3 times a week □ ≥3times a week □ daily □

Una Tenky ☺