

Date: Day ___ Month ___ Year _____ Interviewer Name: _____

Participant Name: _____ ID number: _____ - _____

Date of Birth: Day ___ Month ___ Year _____ Gender: Male Female

Respondent: Participant Participant's mother Participant's father
 Other; specify relation to participant: _____

Person assisting respondent in answering questions: None Participant Parent Interpreter
 Other; specify relation to participant: _____

Place of interview: Participant's home Health centre/Nursing station
 Learning Center Other; specify _____

The purpose of this questionnaire is to collect some basic background and health information for your participation in the project.

1. When you are sick where do you go for care? *Mark all that apply.*

- Health Centre/Nursing Station
- Regional Hospital; specify _____
- Other; specify _____
- Unsure
- Refused to answer

We would like to ask you some questions about *Helicobacter pylori* infection.

2. Have you heard of *Helicobacter pylori* or *H. pylori* infection?

- Yes → → → →
- No
- Unsure / don't remember
- Refused to answer

If yes, ask questions 2a-2c:

2a. Can you tell me what kind of illness it causes as far as you know or from what you have heard?

Yes; specify: _____
 No Unsure Refused to answer

2b. Do you know or have an idea about how people get it?

Yes; specify: _____
 No Unsure Refused to answer

2c. How did you first find out about *H. pylori* infection? *Don't read out options. Mark all that apply.*

TV/Radio Newspapers/magazines
 Nurse/Doctor told me School
 Had it myself Family members who had it
 Friends who had it
 Other; specify: _____
 Unsure/don't remember Refused to answer

3. Are you worried about how *H. pylori* infection might affect your health?
 Yes: Please explain why you are worried: _____
 No Unsure Refused to answer
4. Are you worried about how *H. pylori* infection might affect the health of others?
 Yes: Please explain why you are worried: _____
 No Unsure Refused to answer
5. How interested are you in learning about overall results from the [community name] *H. pylori* project? *Read out options.*
 Very interested Somewhat interested Neutral Not interested
- 5a. Is there something about *H. pylori* or *H. pylori*-related diseases that you are hoping to learn?
 Yes: Please specify: _____
 No Unsure Refused to answer

The next set of questions is about your health.

6. To your knowledge, has anyone in your family been told by a doctor they have *H. pylori* infection?
 Yes → → → → **6a. If yes: Do you mind saying how they are related to you? Mark all that apply.**
 No Parents Grandparents Brother or sister
 Unsure / don't remember Child Aunt, uncle or cousin
 Refused to answer Other relative, specify: _____
7. Have you ever seen a nurse or doctor about stomach or esophagus (the tube that food goes down to get to your stomach) problems?
 Yes → **7a. If yes: How long ago in either years or months?**
 No _____ years _____ months Unsure/don't remember Refused to answer
 Unsure / don't remember
 Refused to answer
8. Have you ever been told by a nurse or doctor you have an ulcer in your stomach or duodenum (beginning of intestinal tract)?
 Yes → **8a. If yes: How long ago in either years or months?**
 No _____ years _____ months Unsure/don't remember Refused to answer
 Unsure / don't remember
 Refused to answer
9. Have you ever been diagnosed by a doctor with acid reflux (heartburn) disease by gastroscopy or pH probe study?
 Yes → **9a. If yes: How long ago in either years or months?**
 No _____ years _____ months Unsure/don't remember Refused to answer
 Unsure / don't remember
 Refused to answer

10a. Has anyone in your family had stomach cancer?

Yes → No

10a1. *If yes: Do you mind saying how they are related to you? Mark all that apply.*

Parents Grandparents Brother or sister Child

Aunt, uncle or cousin Participant self Other relative, specify: _____

Unsure / don't remember

Refused to answer

10b. Has anyone in your family had other cancer?

Yes → No

10b1. *If yes: Do you mind saying how they are related to you? Mark all that apply.*

Parents Grandparents Brother or sister Child

Aunt, uncle or cousin Participant self Other relative, specify: _____

Unsure / don't remember

Refused to answer

11. Have you ever been tested for *H. pylori*, before this research project?

Yes → → → → No

Unsure / don't remember

Refused to answer

If yes, ask questions 11a-e:

11a. How many times were you tested for *H. pylori*? _____

Unsure/don't remember Refused to answer

If tested more than once: 11a1. How long ago in years or months was your most recent test? _____ years _____ months

Unsure/don't remember Refused to answer

11b. How long ago were you first tested for *H. pylori*? _____ years _____ months

Unsure/don't remember Refused to answer

11c. What hospital or health centre were you first tested at? _____

11d. What kind of test did you have for *H. pylori*? *Mark all that apply.*

Breath test Blood test Gastroscopy (camera/scope test)

Other test; specify test: _____

Unsure / don't remember Refused to answer

11e. Have you ever tested positive for *H. pylori*?

Yes No Unsure/don't remember Refused to answer

If yes: 11e1. Was your first H. pylori test positive?

Yes No Unsure/don't remember Refused to answer

If tested more than once: 11e2. Was your most recent H. pylori test positive?

Yes No Unsure/don't remember Refused to answer

12. Have you ever been treated with antibiotics for *H. pylori*?

- Yes → → → →
- No
- Unsure / don't remember
- Refused to answer

If yes, ask questions 12a-e:

12a. How many times were you treated for *H. pylori*?

Unsure/don't remember

Refused to answer

If treated more than once:

12a1. How long ago in years or months was the most recent time that you were treated?

_____ years _____ months

Unsure/don't remember

Refused to answer

12a2. What hospital or health centre were you treated at the most recent time?

12b. How long ago in years or months was the first time you were treated?

_____ years _____ months

Unsure/don't remember

Refused to answer

12c. What hospital or health centre were you treated at the first time?

12d. Did you complete the full course of antibiotics prescribed each time?

Yes

No

Unsure/don't remember

Refused to answer

12e. Did you ever get retested after being treated for *H. pylori* infection?

Yes

No

Unsure/don't remember

Refused to answer

*If yes: 12e1. What hospital or health centre were you retested at for *H. pylori* infection?*

13. Have you ever had a gastroscopy before? This is a scope test with a camera to look inside your stomach.

- Yes → → → →
- No
- Unsure / don't remember
- Refused to answer

If yes, as questions 13a-c:

13a. How many times did you have a scope test of the stomach?

Unsure/don't remember

Refused to answer

13b. How long ago in years or months was your most recent gastroscopy?

_____ years _____ months

Unsure/don't remember

Refused to answer

13c. What hospital or health centre did you have your most recent gastroscopy done?

14. Do you ever take aspirin, also known as ASA or baby aspirin? (*Full name is acetylsalicylic acid*)

- Yes → → →
- No
- Unsure / don't remember
- Refused to answer

15a. *If yes:* How many aspirin do you take in a typical day or a week?

_____ per day _____ per week

less often than weekly

Unsure/don't remember

Refused to answer

15. Do you ever take other anti-inflammatory medications, such as Advil, Motrin, ibuprofen, or something prescribed to you by your doctor? *For example: Naproxen, Naprosyn, Indocid, Indomethacin, Celebrex, Vioxx. This does NOT include Tylenol or acetaminophen.*

Yes: Specify which: _____

a. *If yes:* How many do you take in a typical day or a week? _____ per day _____ per week less often than weekly

No

Unsure

Refused to answer

16. Do you ever take Plavix, also known as clopidogrel? This would be prescribed to you by your doctor. *Used to prevent strokes or heart attacks.*

- Yes → → →
- No
- Unsure / don't remember
- Refused to answer

16a. *If yes:* How many plavix do you take in a typical day or a week?

_____ per day _____ per week less often than weekly

Unsure/don't remember Refused to answer

17. Have you taken any medications for your stomach or heartburn in the last 30 days?

- Yes → → → →
- No
- Unsure / don't remember
- Refused to answer

If yes: 17a. Specify which medications you take for your stomach or heartburn? Don't read options. Mark all that apply.

- 1. Maalox _____ per day _____ per week less often than weekly
- 2. Pepto-Bismol _____ per day _____ per week less often than weekly
- 3. TUMS/Roloids _____ per day _____ per week less often than weekly
- 4. Ranitidine (Zantac) _____ per day _____ per week less often than weekly
- 5. Famotidine (Pepcid) _____ per day _____ per week less often than weekly
- 6. Cimetidine (Tagamet) _____ per day _____ per week less often than weekly
- 7. Pantoprazole (Pantaloc) _____ per day _____ per week less often than weekly
- 8. Omeprazole (Losec) _____ per day _____ per week less often than weekly
- 9. Lansoprazole (Prevacid) _____ per day _____ per week less often than weekly
- 10. Esomeprazole (Nexium) _____ per day _____ per week less often than weekly
- 11. Rabeprazole (Pariet) _____ per day _____ per week less often than weekly
- 12. Vitamins _____ per day _____ per week less often than weekly
- 13. Other medications, specify:
_____ _____ per day _____ per week less often than weekly
- Unsure
- Refused to answer

Now, we will ask you about symptoms related to stomach problems.

18. Do you have difficulty swallowing solid food?

- Yes No Unsure Refused to answer

19. Do you have unexplained weight loss? More than 10% of your normal weight.

- Yes No Unsure Refused to answer

20. Do you have recurrent vomiting?

- Yes No Unsure Refused to answer

We would now like to know about any stomach problems you may have had in the past 6 months. Use the scale below to indicate the severity of your symptoms lasting longer than 3 months. Use the severity scale flowchart provided in the Manual of Procedures if it is helpful.

1. No problem
2. Minimal problem (can be easily ignored without effort)
3. Mild problem (can be ignored with effort)
4. Moderate problem (cannot be ignored but generally does not limit my daily activities)
5. Moderately severe problem (cannot be ignored and occasionally limits my daily activities)
6. Severe problem (cannot be ignored and often limits my daily activities)
7. Very severe problem (cannot be ignored and markedly limits my daily activities and often requires rest)

	1	2	3	4	5	6	7	Unsure	RTA
21. Upper abdominal symptoms, overall	<input type="checkbox"/>								
22. Epigastric, middle of abdomen just below breast bone, <u>pain</u> or unpleasant sensation	<input type="checkbox"/>								
23. Epigastric <u>discomfort</u>	<input type="checkbox"/>								
24. Epigastric <u>burning</u>	<input type="checkbox"/>								
25. Feeling full too long	<input type="checkbox"/>								
26. Feeling full even though you ate a small amount	<input type="checkbox"/>								
27. Heartburn, burning sensation under the lower part of the centre of the chest which rises towards or into the neck	<input type="checkbox"/>								
28. Acid regurgitation, backward flow or sour or bitter fluid from the stomach into the food pipe	<input type="checkbox"/>								
29. Upper abdominal bloating	<input type="checkbox"/>								
30. Excessive belching	<input type="checkbox"/>								
31. Nausea	<input type="checkbox"/>								
32. Other stomach or digestive symptoms	<input type="checkbox"/>								
32a. Specify symptom: _____	<input type="checkbox"/>								
32b. Specify symptom: _____	<input type="checkbox"/>								

33. *This question is for participants of ages 15 years and older.* If the project were to offer endoscopy, which is a thin scope sent down into your stomach to test and look for *H. pylori* infection or other stomach problems, would you be willing to consider undergoing an endoscopy procedure?

- Yes: Specify why: _____
- No: Specify why not: _____
- Unsure: Specify what you would need to make up your mind one way or another: _____
- Refused to answer

<p>→ If no or unsure: 33a. Would you be willing to have a scope test if you found out you have <i>H. pylori</i> infection?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Unsure <input type="checkbox"/> Refused to answer</p>
--

Thank you for taking the time to tell us about your health.