

Verbal Autopsy Questionnaire (CRFs 102-103)

Subject ID:
 Centre # Community # Household # Member #

Subject Initials
 F M L

Baseline ID:
 Centre # U/ R Community/ Village # Household # Study code / Subject ID #

How did this person die? (Write an account of final illness in respondent's own words)

Context and history of previously known medical conditions:

The following questions concern the contexts and previously known medical conditions the deceased had; and the signs and symptoms that the deceased had/showed when he/she was ill. Some of these questions may not appear to be directly related to his/her death but they will help us to get a clear picture of all possible symptoms prior to death.

1. Did he/she die suddenly? ☐ No → Skip to 2. ☐ Yes ☐ Don't Know → Skip to 2.

1a. Was sudden death witnessed ☐ No ☐ Yes

2. Was he/she well during the 12 hours prior to death? ☐ No ☐ Yes → Skip to 3. ☐ Don't Know → Skip to 3.

2a. How long was he/she ill before he/she died?

☐ <12 hours ☐ >12 hours but < 24 hours (1day)

☐ 2-7 days → # of days

☐ >1 week → # of weeks

OR ☐ Don't Know

Symptoms noted during the final illness:

3. Did he/she have any breathing problems? ☐ No → Skip to 4. ☐ Yes ☐ Don't Know → Skip to 4.

3a. Did he/she have fast breathing? ☐ No ☐ Yes ☐ Don't Know

i) If Yes, how long?

of days

OR

of weeks

3b. Did he/she have breathlessness? ☐ No ☐ Yes ☐ Don't Know

i) If Yes, how long?

of days

OR

of weeks

3b(ii). Was he/she unable to carry out daily routines due to breathlessness? ☐ No ☐ Yes ☐ Don't Know

3b(iii). Did he/she have breathlessness on exertion?

☐ No ☐ On vigorous exertion (climbing stairs) ☐ On moderate exertion (rapid walking) ☐ On slight exertion ☐ At rest ☐ Don't Know

3b(iv). Was there breathlessness at night causing the person to wake up after ☐ No ☐ Yes ☐ Don't Know

4. Did he/she have wheezing/whistling in the chest? ☐ No ☐ Yes ☐ Don't Know

5. Did he/she have chronic cough lasting 3 months in the past 2 years? ☐ No ☐ Yes ☐ Don't Know

6. Did he/she have both feet swollen? ☐ No ☐ Yes ☐ Don't Know

Subject ID:

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Baseline ID:

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Symptoms noted during the final illness (continued):

7. Was he/she unconscious for more than 24 hours? ☐ No → *Skip to 8.* ☐ Yes ☐ Don't Know → *Skip to 8.*
 7a. Did the unconsciousness start suddenly/quickly (at least within a single day)? ☐ No ☐ Yes ☐ Don't Know
8. Did he/she have noticeable weight loss? ☐ No ☐ Yes ☐ Don't Know
9. Did he/she drink a lot more water than usual? ☐ No ☐ Yes ☐ Don't Know
10. Did he/she have urine problems? ☐ No → *Skip to 11.* ☐ Yes ☐ Don't Know → *Skip to 11.*
 10a. Did he/she pass no urine at all? ☐ No ☐ Yes ☐ Don't Know

Symptoms noted during the month preceding death:

11. Did he/she have chest pain? ☐ No → *Skip to 12.* ☐ Yes ☐ Don't Know → *Skip to 12.*
 11a. How long did the chest pain last? ☐ < 24 hours ☐ > 24 hours
 11b. Where was the chest pain located? ☐ Central chest ☐ Left chest ☐ Right chest ☐ Other ☐ Don't Know
 11c. Was the chest pain/discomfort accompanied by or followed by:
 i) Sweating ☐ No ☐ Yes ☐ Don't Know
 ii) Unconsciousness ☐ No ☐ Yes ☐ Don't Know
 iii) Vomiting ☐ No ☐ Yes ☐ Don't Know
 iv) Others ☐ No ☐ Yes ☐ Don't Know
 11d. Was there chest pain/discomfort on exertion?
☐ No ☐ On vigorous exertion (climbing stairs) ☐ On moderate exertion (rapid walking) ☐ On slight exertion ☐ At rest ☐ Don't Know
12. Did he/she have paralysis of one or both sides of the body? ☐ No ☐ Yes, one side ☐ Yes, both sides ☐ Don't Know
 12a. **If yes**, was the paralysis accompanied or followed by a sudden loss of consciousness? ☐ No ☐ Yes ☐ Don't Know
13. Was there a pre-existing heart problem at anytime or was heart disease diagnosed as cause of death? ☐ No ☐ Yes ☐ Unknown
 13a. **If yes**, what was the diagnosis (record verbatim)?

14. Were any of the following listed as the diagnosis - verbally or on medical certificate?

- | | | | |
|--|-----------------------------|------------------------------|----------------------------------|
| a) Heart attack | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Unknown |
| b) Angina | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Unknown |
| c) Heart failure | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Unknown |
| d) Heart beat abnormality (irregular heart beat) | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Unknown |
| e) Heart valve defect | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Unknown |
| f) Birth defect of heart or blood vessels | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Unknown |
| g) Fluid around the heart | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Unknown |
| h) Related to heart surgery | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Unknown |
| i) Other _____ | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Unknown |

Specify