<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Ward No.</td>
<td>Panchayath:</td>
</tr>
<tr>
<td></td>
<td>Block:</td>
</tr>
<tr>
<td></td>
<td>Geo-code:</td>
</tr>
<tr>
<td>2. Name</td>
<td></td>
</tr>
<tr>
<td>3. Address</td>
<td></td>
</tr>
<tr>
<td>4. Marital status</td>
<td>Married / Single</td>
</tr>
<tr>
<td>5. Occupation</td>
<td></td>
</tr>
<tr>
<td>6. Annual Income</td>
<td></td>
</tr>
<tr>
<td>7. Habits</td>
<td>Smoking / Drinking</td>
</tr>
<tr>
<td>8. Do you have asthma</td>
<td>Yes / No</td>
</tr>
<tr>
<td>9. Age</td>
<td></td>
</tr>
<tr>
<td>10. Do you have wheezing or whistling sound from chest/</td>
<td>Yes/No</td>
</tr>
<tr>
<td>chest tightness/breathlessness</td>
<td></td>
</tr>
<tr>
<td>11. Are you suffering from Asthma have a attack of Asthma in past 12 months</td>
<td>Yes/No</td>
</tr>
<tr>
<td>12. Are you using inhaler or oral bronchodilators</td>
<td>Yes/No</td>
</tr>
<tr>
<td>13. Age of onset of Asthma</td>
<td></td>
</tr>
<tr>
<td>14. Time of attack</td>
<td>Day / Night / Early morning / Evening</td>
</tr>
<tr>
<td>15. Symptoms at onset</td>
<td>Wheezing, Cough, Breathlessness, Sneezing, Runny Nose, Nose itching, Nose block, Eye itching, Ear itching, Throat itching, Chest pain</td>
</tr>
<tr>
<td>16. Periodicity of Attacks</td>
<td>Daily/Weekly/Monthly/Irregular</td>
</tr>
<tr>
<td>17. Duration</td>
<td>Few Minutes/ Hours Only/ 2-4 Days/ One week/ One Month/Irregular/Others</td>
</tr>
<tr>
<td>18. Sleeping Trouble</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Question</td>
<td>Response</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>19. Influence of Seasonal Variation</td>
<td>Yes/No</td>
</tr>
<tr>
<td>If yes, please mention the season</td>
<td>Winter/Summer/Rainy/Non Specific</td>
</tr>
<tr>
<td>20. Do you have Dust Allergy</td>
<td>Yes / No</td>
</tr>
<tr>
<td>If yes,</td>
<td>Outdoor / Indoor / Hay Dust</td>
</tr>
<tr>
<td>21. Do you have</td>
<td></td>
</tr>
<tr>
<td>a) Skin allergy</td>
<td>Yes / No</td>
</tr>
<tr>
<td>b) Drug allergy</td>
<td>Yes / No</td>
</tr>
<tr>
<td>c) Food allergy</td>
<td>Yes / No</td>
</tr>
<tr>
<td>22. Do you have cushioned Furniture?</td>
<td>Yes / No</td>
</tr>
<tr>
<td>If yes, please specify</td>
<td></td>
</tr>
<tr>
<td>23. Type of bedding used at home</td>
<td>Cotton / Foam / Wool / Others</td>
</tr>
<tr>
<td>24. Type of Roof</td>
<td>Tiled / Concrete / Coconut leaves / Hay thatched / Asbestos</td>
</tr>
<tr>
<td>25. Domestic animals / birds at Home</td>
<td></td>
</tr>
<tr>
<td>Indoor</td>
<td>Dog, Cat, Rabbit,</td>
</tr>
<tr>
<td>Outdoor</td>
<td>Dog, Cat, Rabbit, Cow, Goat, Pig, Squirrel, Fowl, Pigeon, Parrot</td>
</tr>
<tr>
<td>26. Occurrence of Cockroaches in your home</td>
<td>Nil, Rare, Moderate, High</td>
</tr>
<tr>
<td>27. Type of vegetation in your Neighborhood</td>
<td>Ornamental plants / Crops / Grasses / Trees / Weeds</td>
</tr>
<tr>
<td>Please specify the name</td>
<td></td>
</tr>
<tr>
<td>28. Ventilation system in the Home</td>
<td>Good/Moderate/Poor</td>
</tr>
<tr>
<td>29. Weathering of Roof/wall</td>
<td>Nil / Moderate / High</td>
</tr>
<tr>
<td>30. Moisture in the walls/Roofs</td>
<td>Nil / Moderate / High</td>
</tr>
<tr>
<td>31. Cracks and holes in the walls / near wash basin</td>
<td>Yes / No</td>
</tr>
<tr>
<td>32. Mold attack in the walls/Roofs</td>
<td>Nil / Moderate / High</td>
</tr>
<tr>
<td>33. Flooring</td>
<td>Muddy/Cemented/Mosaic/Marble / Granite/Tiled / Carpeted</td>
</tr>
</tbody>
</table>
34. Cleanliness : Good / Moderate / Poor
35. Source of light inside the house : Electricity/Solar/Kerocine/Others
36. Have you had any long term treatment for allergy/asthma before : Yes / No
37. Events of Hospitalization : Yes / No
38. Name of Doctor and Hospital you are visiting for the treatment :
39. Any of your family member has been suffering from Asthma : Father / Mother / Brothers / Sisters / Husband / Wife / Children / Others

### Details of Asthmatic Patients

<table>
<thead>
<tr>
<th>No</th>
<th>Name</th>
<th>Sex</th>
<th>Age</th>
<th>Age of onset of Asthma</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>M</td>
<td>F</td>
<td></td>
</tr>
</tbody>
</table>

40. Other Diseases usually or recently occurred in your family :

Name & Signature of the respondent:

Name & Signature of the Interviewer:

Place:
Date:
## LIST OF PUBLICATIONS

<table>
<thead>
<tr>
<th>Papers Published in Journals: 5</th>
</tr>
</thead>
</table>

### International


### National


### Papers Published in Seminar Proceedings :5

### International