Appendix - II

Interview Schedule
General Schedule No.:__________ Schedule No.:__________

REPRODUCTIVE AND CHILD HEALTH PROBLEMS AMONG THE PRIMITIVE TRIBES OF NILGIRI HILLS
(An Operational Research Study)
(Sponsored by The Indian Council of Medical Research, Government of India, New Delhi)

Principal Investigator: Dr. T.S. Naidu, Pondicherry University, Pondicherry – 605 014.

Female Reproductive General Gynaecological Observation Schedule

I. General Information
   1.1. Name:
   1.2. Occupation (if any):
   1.3. Name of the husband:
   1.4. Occupation:
   1.5. Address:

   1.6. Name of the Village:
   1.7. Name of the tribe:
   1.8. Date of Birth: __________ Age:
   1.9. Marital Status: Married / Unmarried / Divorced / Widow / Separated / Others
   1.10. Height: __________ Cms
   1.11. Weight: __________ Kgs
   1.12. Arm circumference: __________ Cms

II. Menarche
   2.1. The age when you attained puberty: __________
   2.2. When you attained second menstruation: __________
   2.3. What is the menstrual duration: __________
   2.4. How many periods do you have in the last year? __________
   2.5. What is the usual gap between successive periods? __________
   2.6. Do you observe any irregularity with regard to periods? Yes / No
   2.7. Have you ever had painful periods? Yes / No
   2.8. If Yes (a) What are the reasons?

      (b) What remedy do you use to take?
2.9 Do you go for intercourse during menses? Yes / No
2.10 How many days after menses you for intercourse? _______ days
2.11. How many days before menses you go for intercourse? _______ days
2.12. What taboos do you observe during menses?
   Food:
   Movement Restriction:
   Interpersonal relations:
   Religious:
   Other (specify)

III. Marriage
3.1 At what age you got married? ______ Your husband's age at the time of marriage ______
3.2. Whether the married partner is related? Yes / No
3.3. If yes mention the relationship _______________
3.4. What type of marriage is yours: Arranged/Love/Elopement/Other ______

IV. Conception
4.1 Do you have pain during intercourse? Yes / No
4.2. Frequency of intercourse per week ______
4.3 Enter the total number of times you have been pregnant? ______
4.4. Age at First Pregnancy :
4.5. Age at current Pregnancy if any :
4.6. Enter number of abortions (if any) ______Spontaneous ______Induced ______
4.7. In case induced what method adopted :
4.8. Have you ever had an abnormal pap? Yes / No
4.9. If yes, when did you have an abnormal pap? ______________
4.10. If yes how you treated it?
4.11. Have you ever had cervical problems · Yes/No
4.12. If yes what is the treatment given
4.13. Ever had any of the following problems?
   Abnormal male hair growth pattern / Breast discharge / Gonorrhea
   Syphilis / Herpes / Chlamydia
4.14. Do you have a history of : Fibroids/Ovarian cysts/ Pelvic infections/ Endometriosis/
   Infertility?
4.15 Do you have any medical problems has mentioned below:
   IE / Hypertension / Diabetes / Seizures / Asthma / Allergies.
4.16. Have you ever had surgery/treatment on your pelvic organs: Hysterectomy / Tubal ligations / Colization / Laparoscopy.

4.17. Have you ever been checked for the AIDS virus? Yes / No If yes, when? ______

4.18. Do you have any blood transfusion? Yes / No

4.19. If yes When ________________ From whom ________________ For what ________________

4.20. Please indicate and explain the following problems if any in the history of your family:

- Infertility ................................................................. ..................................................
- Recurrent miscarriage .......................................................... ........................................
- Down Syndrome or Mongolism ................................................................. ..........................
- Adult onset Polycystic Kidney Diseases ................................................................. ..........................
- Adult onset neurological disease ................................................................. ..........................
- Muscular dystrophy ..........................................................................................................
- Blood clot in leg or lung ...................................................................................................
- Congenital heart disease ..................................................................................................
- Mental retardation ..........................................................................................................
- Mental illness ..................................................................................................................
- Birth defects of any kind .................................................................................................
- Heart disease or hypertension ........................................................................................
- Paralysis ..........................................................................................................................
- Multiple birth ..................................................................................................................
- Family history of cancer (breast, colon, uterine, ovarian, cervical) ...................... ..........................................

4.21. Do you drink alcohol? Yes / No

4.22. If Yes how frequent:

4.23. How much alcohol do you consume every time?

4.24. Do you chew: Tobacco / Betel / Ghutka

4.25. If yes how frequent and in what amount:

- Tobacco ____________ Betel ____________ Ghutka ____________

4.26. Do you take black coffee/tea: Yes/No

4.27. If yes how often and in what amount: Coffee ____________ Tea ____________

4.28. Have you taken tetanus injection? Yes / No

4.29. Have you taken hepatitis vaccine? (Select one) A / B · Yes / No

4.30. Have you had pneumoccal vaccination? Yes / No

4.31. How many brothers & Sisters do you have? Brothers ____________ Sisters ____________

4.32. Mother (Living, Deceased; cause of death) ____________

4.33. Father (Living, Deceased; cause of death) ____________
V Delivery / Live Birth

5.1. Number of Living Children: Male _________ Female _________

5.2. Number of children died: Male _________ Female _________

5.3. Number of Still Births: _________

5.4. Spacing between current and previous pregnancy (in months):

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<td>5.5 Space between successive pregnancies</td>
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<td>5.6. Nature of Successive deliveries</td>
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<td>5.7. Place of deliveries</td>
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<td>5.8 Who attended the delivery</td>
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Place of delivery 1. House, 2. Hospital, 3. PHC, 4. Other (specify)


5.10. What was used for tying the cord: Thread/Rubber band/Cloth/Bandage/Others.

5.11. What was applied after cord cutting: Nothing/Oil/Cow dung/Herbal paste/Turmeric/Talcum powder/Coffee powder/Sandal powder/Others.

5.12. Explain the delivery posture:

5.13. Do you breast feed your baby immediately after delivery? Yes/No

VI. Ovulation / Menopause

6.1. Have you undertaken any Birth Control Methods: Yes/No

6.2. If Yes specify: Birth control pills? _______ Intrauterine Device? _______ Condom? _______

6.3. At what age you attained Menopause:

6.4. What health problems you faced before onset of Menopause?

6.5. What health problems you faced after the Menopause?

6.6. What was the social respect you have after Menopause?

6.7. Do you perform any ritual during the menopause starts?