

PE.1.1.1 □□□ / PE.1.1.2 □□□ mmHg	
B.5 During the past 3 months, how often have you eaten pickled foods? <input type="checkbox"/> ₁ Hardly ever <input type="checkbox"/> ₂ Occasionally <input type="checkbox"/> ₃ 1-2 times/week <input type="checkbox"/> ₄ 3-6 times/week <input type="checkbox"/> ₅ At least once a day	B.6 During the past 3 months, what did you do when you found the food was not salty enough to your taste? <input type="checkbox"/> ₁ Always eat pickles/add soy sauce/add salt <input type="checkbox"/> ₂ Sometimes eat pickles/add soy sauce/add salt <input type="checkbox"/> ₃ Did not eat pickles/add soy sauce/add salt

B.7 High salt intake will: <input type="checkbox"/> ₁ worsen your health <input type="checkbox"/> ₂ improve your health <input type="checkbox"/> ₃ have no effect on your health <input type="checkbox"/> ₄ Not sure	B.8 Which of the following can help reduce blood pressure? (read out one by one) B.8.1Medicine: <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₉ Don't know B.8.2Smoking: <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₉ Don't know B.8.3Eating less salt: <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₉ Don't know B.8.4Eating more food: <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₉ Don't know	B.9 What is the daily recommended salt intake for adults? <input type="checkbox"/> ₁ No salt <input type="checkbox"/> ₂ ≤6g salt <input type="checkbox"/> ₃ >6 g salt <input type="checkbox"/> ₄ Not sure
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C. Disease history

C.1 Do you have diabetes?
₁. Yes ₀.No ₉. Don't know (if No or Don't know, go to C.2)
₁ → C1.1 Diagnosed at a county or higher level hospital?
₁. Yes ₀. No ₉. Don't know

C.2 Have you ever had a stroke?
₁. Yes ₀.No ₉. Don't know (if No or Don't know, go to C.3)
₁ → C.2.1 Diagnosed at a county or higher level hospital?
₁. Yes ₀. No ₉. Don't know
 C.2.2 Was it an ischemic stroke or hemorrhagic stroke?
₁. Ischemic stroke ₂. Hemorrhagic stroke ₃. Don't know

C.3 Do you have coronary heart disease?
₁. Yes ₀. No ₉. Don't know (if No or Don't know, go to C.4)
₁ → C.3.1 Diagnosed at a county or higher level hospital?
₁. Yes ₀. No ₉. Don't know
 C.3.2 Did the doctor tell you that your ECG was abnormal?
₁. Yes ₀. No ₃. Did not have ECG done ₉. Don't know

C.4 Do you have hypertension (HTN)?
₁. Yes ₀. No ₉. Don't know (if No or Don't know, go to C.5)
₁ → C.4.1 How many years have you had hypertension (HTN)? _____ Years ₉. Don't know
 C.4.2 Was the HTN diagnosed before 10/2008? ₁. Yes ₀. No ₉. Don't know

C.5 Have you had your blood pressure measured after age 50 (male)/60 (female)?
₁. Yes ₀.No ₉. Don't know (if No or Don't know, go to C.6)
₁ → C.5.1 Please provide the highest systolic blood pressure measured □□□ mmHg (If Don't know, fill as 999)

C.6 During the past two weeks, have you been taking any anti-hypertensive medication?

- ₁. Yes ₀. No ₉. Don't know

C.7 During the past 12 months, did you see your village doctor once a month?

- ₁. Yes
₀. No

C.8 Did your village doctor measure your blood pressure at each visit?

- ₁. Never saw village doctor ₂. Never measured
₃. Sometimes(occasionally) ₄. Almost every time
₅. Every time

Physical examination (PE.2). Blood pressure and heart rate measurement (2nd)

PE.2.1 Blood pressure (Systolic/Diastolic)

PE.2.1.1 □ □ □ / PE.2.1.2 □ □ □ mmHg

PE.2.2 Heart rate:

□ □ □ /minute

CL. CVD high-risk patient confirmation checklist (CL) for the interviewer

CL.1 Has reported a history of diabetes (C.1.1 answer Yes)

- ₁.Yes ₀.No

CL.2 Has reported a history of stroke (C.2.1 answer Yes)

- ₁.Yes ₀.No

CL.3 Has reported a history of CHD (Both C.3.1 and C.3.2 answer Yes)

- ₁.Yes ₀.No

CL.4 Has reported a history of SBP \geq 160mmHg with older age (C.5.1)

- ₁.Yes ₀.No

CL.5 Systolic BP measurement \geq 160mmHg **twice** (PE.1.1 and PE.2.1)

- ₁.Yes ₀.No

If the answer to any of the above questions is Yes, continue the survey; otherwise go to PE.3 to measure participant's height and weight

D. Medication use and medical care (high-risk patients ONLY)

D.1 When was the last time that you saw your village doctor for heart disease, stroke, diabetes, or HTN? _____ days ago
During that visit, did the village doctor provide any of the following recommendations?

- D.1.1 Reduce salt intake ₁.Yes ₀.No
D.1.2 Quit smoking ₁.Yes ₀.No ₉.Not applicable
D.1.3 Avoid binge drinking ₁.Yes ₀.No ₉.Not applicable
D.1.4 Be physically active ₁.Yes ₀.No
D.1.5 Control weight ₁.Yes ₀.No ₉.Not applicable

D.2 During the past 12 months, have you been hospitalized due to heart disease, stroke, diabetes or hypertension?
(exclude hospitalization for other reasons) ₁.Yes ₀.No (If no, go to D.3)

D.2.1 How many times have you been in the hospital? _____

D.2.2 How many days have you been in the hospital? _____

D.2.3 How much did you spend in out of pocket expenses for the hospitalization? _____ RMB (Note: put "00" before number if only know total expenditure; fill in "-999" if don't know)

D.3 During the past 12 months, how many months have you taken anti-hypertensive medication (AHM)?

- ₀.None
₁.Not sure if the medication taken was AHM
₂. <2 months

D.3.1 Who prescribed the AHM for you?

- ₁. Self-prescribed/bought
₂. TCM doctor
₃. Specialist (town or higher level)
₄. Village doctor and specialist
₅. Village doctor

D.3.3 Where do you buy AHM mainly?

- ₁. Village clinic
₂. Township center
₃. County hospitals
₄. Pharmacies

- ₃ 2-8 months
₄ 9-11 months
₅ =12 months

(if none or not sure, go to D.4)

D.3.2. Has the village doctor ever adjusted the treatments, either titrating the dosage or changing the prescription for you?

- ₁.Yes ₀.No ₉.Dont' know

D.4 During the past 12 months, how many months have you taken aspirin?

- ₀.None
₁.Not sure if the medication taken was Aspirin
₂.<2 months
₃. 2-8 months
₄ 9-11 months
₅ =12 months

(if not a long-term user or don't know, go to D.5)

D.4.1 Who prescribed the aspirin?

- ₁ Self prescribed/bought
₂. TCM doctor
₃. Specialist
₄. Village doctor and specialist
₅. Village doctor

D.4.2 Where do you buy aspirin mainly?

- ₁. Village clinic
₂. Township center
₃. County hospitals
₄. Pharmacies

D.5 During the past month, have you taken any medications for your heart disease, stroke, diabetes or hypertension?

- ₁.Yes ₉.Don't know ₀.No (if No, go to PE.3 to measure height and weight)

D.5.1 Medicine (brand name)	D.5.2 Taken daily? (≥25days in the last 30 days)	D.5.3 Prescribed by a village doctor?
1.	<input type="checkbox"/> ₁ .Yes <input type="checkbox"/> ₀ .No	<input type="checkbox"/> ₁ .Yes <input type="checkbox"/> ₀ .No
2.	<input type="checkbox"/> ₁ .Yes <input type="checkbox"/> ₀ .No	<input type="checkbox"/> ₁ .Yes <input type="checkbox"/> ₀ .No
3.	<input type="checkbox"/> ₁ .Yes <input type="checkbox"/> ₀ .No	<input type="checkbox"/> ₁ .Yes <input type="checkbox"/> ₀ .No
4.	<input type="checkbox"/> ₁ .Yes <input type="checkbox"/> ₀ .No	<input type="checkbox"/> ₁ .Yes <input type="checkbox"/> ₀ .No
5.	<input type="checkbox"/> ₁ .Yes <input type="checkbox"/> ₀ .No	<input type="checkbox"/> ₁ .Yes <input type="checkbox"/> ₀ .No

If more than 5, and if the drug category is uncertain, copy the names of the remaining medications in the blank field below and give the numerical answers for D5.2 and D5.3. 1=Yes, 0=No

Physical examination (PE.3). Body height and weight measurement for all survey participants

PE.3.1 Height □□□. □ cm

PE.3.2 Weight □□□. □ kg

Body not straight? ₁.Yes ₀.No

(End of survey)

Interviewer comments/impressions:

- Interviewee understands questions well
 Interviewee understands questions partly
 Interviewee understands questions poorly

Interviewer introspect the completeness of questionnaire.

Time of completion: □□ : □□



ID Code: 2010□□ / □□ / □□ / □□ / □□□
Province / County / Town / Village / Participant ID

Interviewer signature: _____

Date of quality control review: 2010 __ month__ day. Time □□ : □□

Quality control reviewer signature: _____

PE.1.1.1 <input type="text"/> <input type="text"/> <input type="text"/> / PE.1.1.2 <input type="text"/> <input type="text"/> <input type="text"/> mmHg			
B.5 During the past 3 months, how often have you eaten pickled foods? <input type="checkbox"/> ₁ Hardly ever <input type="checkbox"/> ₂ Occasionally <input type="checkbox"/> ₃ 1-2 times/week <input type="checkbox"/> ₄ 3-6 times/week <input type="checkbox"/> ₅ At least once a day		B.6 During the past 3 months, what did you do when you found the food was not salty enough to your taste? <input type="checkbox"/> ₁ Always eat pickles/add soy sauce/add salt <input type="checkbox"/> ₂ Sometimes eat pickles/add soy sauce/add salt <input type="checkbox"/> ₃ Did not eat pickles/add soy sauce/add salt	
B.7 High salt intake will: <input type="checkbox"/> ₁ worsen your health <input type="checkbox"/> ₂ improve your health <input type="checkbox"/> ₃ have no effect on your health <input type="checkbox"/> ₄ Not sure	B.8 Which of the following can help reduce blood pressure? (read out one by one) B.8.1 Medicine: <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₉ Don't know B.8.2 Smoking: <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₉ Don't know B.8.3 Eating less salt: <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₉ Don't know B.8.4 Eating more food: <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₉ Don't know	B.9 What is the daily recommended salt intake for adults? <input type="checkbox"/> ₁ No salt <input type="checkbox"/> ₂ ≤6g salt <input type="checkbox"/> ₃ >6 g salt <input type="checkbox"/> ₄ Not sure	
B.10 Do you pay any attention to reducing your salt intake in your daily diet? <input type="checkbox"/> ₁ A lot of attention (have eliminated pickled vegetables from diet, add less salt and no MSG to cooking, if foods are too salty will not continue to eat) <input type="checkbox"/> ₂ Some attention (decreased intake of pickled vegetables, add less salt during cooking, if foods are too salty will make sure to eat less) <input type="checkbox"/> ₃ No attention (have not decreased the intake of pickled vegetables or salt in any way)			
B.11 Does your household use low-sodium salt? <i>(Investigator should show interviewee one packet of low-sodium salt .that is available in local stores. If the interviewee does not know the answer, the investigator should make every effort to obtain the following information from another member in the same household before ticking 'Don't know')</i>			
<input type="checkbox"/> ₁ Yes			
<div style="border: 1px solid black; padding: 5px;"> B11.1 What is the proportion of low-sodium salt consumption among total salt intake in your household? _____ % <i>(The investigator should make an estimate after detailed inquiry of the household's salt intake, for instructions on inquiry and estimation, please refer to the Instruction Manual on how to complete the questionnaire.)</i> B11.2 When did your household start using low-sodium salt? <input type="checkbox"/>₁ _____ year _____ month <input type="checkbox"/>₉ Don't know B11.2.1 Since then, have you been consistently using low-sodium salt up to now? <input type="checkbox"/>₁ Yes <input type="checkbox"/>₂ No; total time not using low-sodium salt? _____ Months <i>(If don't remember, then fill in the blank with "999".)</i> <input type="checkbox"/>₉ Don't know </div>			
<input type="checkbox"/> ₂ No			
<div style="border: 1px solid black; padding: 5px;"> B11.3 Why do you not use a low-sodium salt? (can choose more than one answer) <input type="checkbox"/>₁ Can't buy it nearby <input type="checkbox"/>₂ Too expensive <input type="checkbox"/>₃ Not very tasty <input type="checkbox"/>₄ Feel not effective <input type="checkbox"/>₅ Worried about side-effects </div>			

₆ Had side-effects after eating _____ (please explain) ₇ No interest ₈ Never heard of "low-sodium salt"
₉ Don't know ₁₀ Other _____ (please explain)

₃ I don't know what kind of salt is used in my household.

C. Disease history

C.1 Do you have coronary heart disease?

₁. Yes ₀. No ₉. Don't know (if No or Don't know, go to C.2)

→ C.1.1 Diagnosed at a county or higher level hospital?
₁. Yes ₀. No ₉. Don't know

C.1.2 Did the doctor tell you that your ECG was abnormal?
₁. Yes ₀. No ₃. Did not have ECG done ₉. Don't know

C.1.3 When were you diagnosed for the first time?
____year__month (if the interviewee didn't remember, then fill the blank with "9999 year 99 month")

C.1.4 when was your last incidence?
____year__month (if the interviewee didn't remember, then fill the blank with "9999 year 99 month")

C.2 Have you ever had a stroke?

₁. Yes ₀. No ₉. Don't know (if No or Don't know, go to C.3)

→ C.2.1 Diagnosed at a county or higher level hospital?
₁. Yes ₀. No ₉. Don't know

C.2.2 Was it an ischemic stroke or hemorrhagic stroke?
₁. Ischemic stroke ₂. Hemorrhagic stroke ₃. Don't know

C.2.3 When were you diagnosed for the first time?
____year__month (if the interviewee didn't remember, then fill the blank with "9999 year 99 month")

C.2.4 when was your last incidence?
____year__month (if the interviewee didn't remember, then fill the blank with "9999 year 99 month")

C.3 Do you have diabetes?

₁. Yes ₀. No ₉. Don't know (if No or Don't know, go to C.2)

→ C.3.1 Diagnosed at a county or higher level hospital?
₁. Yes ₀. No ₉. Don't know

C.3.2 When were you diagnosed for the first time?
____year__month (if the interviewee didn't remember, then fill the blank with "9999 year 99 month")

C.4 Do you have hypertension (HTN)?

₁. Yes ₀. No ₉. Don't know (if No or Don't know, go to C.5)

→ C.4.1 How many years have you had hypertension (HTN)? _____ Years ₉. Don't know

C.4.2 Was the HTN diagnosed before 10/2010? ₁. Yes ₀. No ₉. Don't know

Please confirm the age of the subjects: 50 years old and above for man / 60 years old and above for women:

₁. Yes ₂. No (Go to C.6)

C.5 Have you had your blood pressure measured after age 50 (male)/60 (female)?

₁. Yes ₀. No ₉. Don't know (if No or Don't know, go to C.6)

→ C.5.1 Please provide the highest systolic blood pressure measured mmHg (If Don't know, fill as 999)

C.6 During the past two weeks, have you been taking any anti-hypertensive medication?

₁. Yes ₀. No ₉. Don't know

C.7 During the past one year, have you had any of the following symptoms or illnesses? (read out one by one, put 'X' if yes, '0' if no, do not leave the choice as blank)

- ₁ Dizziness ₂ Headache ₃ Weakness ₄ Fall ₅ Gingival bleeding or subcutaneous hemorrhage ₆ Stomachache ₇ Hyperkalemia ₈ Gastrointestinal bleeding confirmed by a doctor ₉ Renal insufficiency confirmed by a doctor ₁₀ Heart failure confirmed by a doctor ₁₁ Cerebral hemorrhage confirmed by a doctor ₁₂ Hypotension confirmed by a doctor (Lowest blood pressure value ___/___mmHg) ₁₃ Hypoglycemia confirmed by a doctor (Lowest blood glucose level _____mmol/L) ₁₄ Any life-threatening condition requiring hospitalization or prolonging hospitalization (describe condition _____) ₁₅ Other diseases confirmed by the doctor (describe _____)

C.8 During the past 12 months, did you see your village doctor once a month?

- ₁ Yes
₀ No

C.9 Did your village doctor measure your blood pressure at each visit?

- ₁ Never saw village doctor ₂ Never measured
₃ Sometimes (occasionally) ₄ Almost every time
₅ Every time

Physical examination (PE.2). Blood pressure and heart rate measurement (2nd)

PE.2.1 Blood pressure (Systolic/Diastolic)

PE.2.1.1 / PE.2.1.2 mmHg

PE.2.2 Heart rate:

/minute

CL. CVD high-risk patient confirmation checklist (CL) for the interviewer

- | | |
|---|--|
| CL.1 Has reported a history of CHD (Both C.1.1 AND C.1.2 answer Yes) | <input type="checkbox"/> ₁ .Yes <input type="checkbox"/> ₀ .No |
| CL.2 Has reported a history of stroke (C.2.1 answer Yes) | <input type="checkbox"/> ₁ .Yes <input type="checkbox"/> ₀ .No |
| CL.3 Has reported a history of diabetes (C.3.1 answer Yes) | <input type="checkbox"/> ₁ .Yes <input type="checkbox"/> ₀ .No |
| CL.4 Has self-reported a history of SBP \geq 160mmHg with older age (C.5.1) | <input type="checkbox"/> ₁ .Yes <input type="checkbox"/> ₀ .No |
| CL.5 Systolic BP measurement \geq 160mmHg twice (PE.1.1 and PE.2.1) | <input type="checkbox"/> ₁ .Yes <input type="checkbox"/> ₀ .No |

If the answer to any of the above questions is Yes, continue the survey; otherwise go to PE.3 to measure participant's height and weight

D. Medication use and medical care (high-risk patients ONLY)

D.1 When was the last time that you saw your village doctor for heart disease, stroke, diabetes, or HTN? _____ days ago

During that visit, did the village doctor provide any of the following recommendations?

- D.1.1 Reduce salt intake ₁.Yes ₀.No
- D.1.2 Quit smoking ₁.Yes ₀.No ₉.Not applicable
- D.1.3 Avoid binge drinking ₁.Yes ₀.No ₉.Not applicable
- D.1.4 Be physically active ₁.Yes ₀.No
- D.1.5 Control weight ₁.Yes ₀.No ₉.Not applicable

D.2 During the past 12 months, have you been hospitalized due to heart disease, stroke, diabetes or hypertension?

(exclude hospitalization for other reasons) ₁.Yes ₀.No (If no, go to D.3)

D.2.1 How many times have you been in the hospital? _____

D.2.2 How many days have you been in the hospital? _____

D.2.3 How much did you spend in out of pocket expenses for the hospitalization? _____ RMB (Note: put "00" before number if only know total expenditure; fill in "-999" if don't know)

D.3 During the past 12 months, how many months have you taken anti-hypertensive medication (AHM)?

- ₀.None
- ₁.Not sure if the medication taken was AHM
- ₂.<2 months
- ₃.2-8 months
- ₄.9-11 months
- ₅.=12 months

(if none or not sure, go to D.4)

D.3.1 Who prescribed the AHM for you?

- ₁. Self prescribed/bought
- ₂. TCM doctor
- ₃. Specialist (town or higher level)
- ₄. Village doctor and specialist
- ₅. Village doctor

D.3.3 Where do you buy AHM?

- ₁. Village clinic
- ₂. Township center
- ₃. County hospitals
- ₄. Pharmacies

D.3.2. Has the village doctor ever adjusted the treatments, either titrating the dosage or changing the prescription for you?

- ₁.Yes ₀.No ₉.Dont' know

D.4 During the past 12 months, how many months have you taken aspirin?

- ₀.None
- ₁.Not sure if the medication taken was Aspirin
- ₂.<2 months
- ₃.2-8 months
- ₄.9-11 months
- ₅.=12 months

(if not a long-term user or don't know, go to D.5)

D.4.1 Who prescribed the aspirin?

- ₁ Self prescribed/bought
- ₂. TCM doctor
- ₃. Specialist
- ₄. Village doctor and specialist
- ₅. Village doctor

D.4.2 Where do you buy aspirin?

- ₁. Village clinic
- ₂. Township center
- ₃. County hospitals
- ₄. Pharmacies

D.5 During the past month, have you taken any medications for your heart disease, stroke, diabetes or hypertension?

- ₁.Yes ₉.Don't know ₀.No (if No, go to PE.3 to measure height and weight)

D.5.1 Medicine (brand name)	D.5.2 Taken daily? (≥ 25 days in the last 30 days)	D.5.3 Prescribed by a village doctor?
1.	<input type="checkbox"/> ₁ .Yes <input type="checkbox"/> ₀ .No	<input type="checkbox"/> ₁ .Yes <input type="checkbox"/> ₀ .No
2.	<input type="checkbox"/> ₁ .Yes <input type="checkbox"/> ₀ .No	<input type="checkbox"/> ₁ .Yes <input type="checkbox"/> ₀ .No
3.	<input type="checkbox"/> ₁ .Yes <input type="checkbox"/> ₀ .No	<input type="checkbox"/> ₁ .Yes <input type="checkbox"/> ₀ .No
4.	<input type="checkbox"/> ₁ .Yes <input type="checkbox"/> ₀ .No	<input type="checkbox"/> ₁ .Yes <input type="checkbox"/> ₀ .No
5.	<input type="checkbox"/> ₁ .Yes <input type="checkbox"/> ₀ .No	<input type="checkbox"/> ₁ .Yes <input type="checkbox"/> ₀ .No
If more than 5, and if the drug category is uncertain, copy the names of the remaining medications in the blank field below and give the numerical answers for D5.2 and D5.3. 1=Yes, 0=No		

Physical examination (PE.3). Body height and weight measurement for all survey participants

PE.3.1 Height . cm

PE.3.2 Weight . kg

Body not straight? ₁.Yes ₀.No

(End of survey)

Interviewer comments/impressions:

- Interviewee understands questions well
- Interviewee understands questions partly
- Interviewee understands questions poorly

Interviewer introspect the completeness of questionnaire.

Time of completion: :

Interviewer signature: _____

Date of quality control review: 2012 __ month__ day. Time: :

Quality control reviewer signature: _____