



**CHRISTIAN MEDICAL COLLEGE**  
**VELLORE – 632 004, TAMIL NADU, INDIA**  
**DEPARTMENT OF DISTANCE EDUCATION &**  
**RURAL UNIT FOR HEALTH & SOCIAL ACTION**

**ANNEXURE 1**  
**(To be filled by the candidate)**

**A. PERSONAL**

<i>Fill-up/tick wherever appropriate:</i>							
A1. Your Name							
A2. No. of members in your family		A3. What do you do when your family members fall sick?					
A4. Details of your Family members							
Relation to you	Age	Staying with you		Relation to you	Age	Staying with you	
Spouse		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Parent		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Child 1		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Parent		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Child 2		Yes <input type="checkbox"/>	No <input type="checkbox"/>	others		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Child 3		Yes <input type="checkbox"/>	No <input type="checkbox"/>	others		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Child 4		Yes <input type="checkbox"/>	No <input type="checkbox"/>	others		Yes <input type="checkbox"/>	No <input type="checkbox"/>

**B. HEALTH:**

B1. Write 3 common illnesses seen in your locality:

- a)
- b)
- c)

<i>Fill-up/tick wherever appropriate:</i>									
B2	Is there a hospital in your locality?	Yes <input type="checkbox"/>			No <input type="checkbox"/>				
B3	How far is the nearest hospital?	Less than 5 km <input type="checkbox"/>	5-20 km <input type="checkbox"/>	More than 20km <input type="checkbox"/>					
B4	If it is a private hospital, how big is it?	Clinic /Dispensary <input type="checkbox"/>			With admission facilities <input type="checkbox"/>				
B5	If it is a government hospital, how big is it?	Sub-centre <input type="checkbox"/>	PHC <input type="checkbox"/>	Taluk Hospital <input type="checkbox"/>	District hospital <input type="checkbox"/>				
B6	Is there a doctor available all the 24 hours at this hospital?	Yes <input type="checkbox"/>			No <input type="checkbox"/>				
B7	When people fall sick in your locality, where do they go first for treatment?	Poojari <input type="checkbox"/>	Traditional practitioners <input type="checkbox"/>		Nurse <input type="checkbox"/>	Hospital <input type="checkbox"/>			
B8	How many traditional practitioners are there in your locality?	1	2	3	4	More than 4			
B9	How much do the traditional practitioners usually charge the people for treatment?	less than Rs.20 <input type="checkbox"/>	Rs.20 -50 <input type="checkbox"/>	Rs.50- 100 <input type="checkbox"/>	Rs.100- 200 <input type="checkbox"/>	More than Rs.200 <input type="checkbox"/>			
B10	Do pregnant women in your locality have any form of check up during pregnancy?	Yes <input type="checkbox"/>			No <input type="checkbox"/>				
B11	If yes, who does the check up?	Health worker <input type="checkbox"/>			Nurse <input type="checkbox"/>		Doctor <input type="checkbox"/>		



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B12	Do pregnant women in your area get calcium and iron tablets during pregnancy and breast feeding?	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>									
B13	Where do majority of the pregnant women deliver in your locality?	<b>Home</b> <input type="checkbox"/>	<b>Hospital</b> <input type="checkbox"/>									
B14	Who conducts the deliveries at home?	<b>Village women</b> <input type="checkbox"/>	<b>Health worker</b> <input type="checkbox"/>	<b>Nurse</b> <input type="checkbox"/>								
B15	Do many women die during childbirth in your locality?	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>									
B16	How many women have died during childbirth in your locality in the last one year? ( <i>approximately</i> )	0	1	2	3	4	5	6	7	8	9	10
B17	Do children get regular vaccination?	<b>Yes</b> <input type="checkbox"/>					<b>No</b> <input type="checkbox"/>					
B18	How many babies have died during or soon after delivery in your locality in the last one year?	0	1	2	3	4	5	6	7	8	9	10
B19	How many children (1-10 years of age) have died in your locality in the last one year? ( <i>approximately</i> )	0	1	2	3	4	5	6	7	8	9	10
B20	What is the usual cause of the death in these children?											
B21	What do you know about National Rural Health Mission (NRHM) and the health benefits available through NRHM?											

B22. Do you think there are wrong practices / beliefs among the people in your area related to the following? If so, what are they?

Related to food	
Related to diseases	
Related to Pregnancy and delivery	

**C. SOCIAL**

**Please tick the single most appropriate answer for each of the questions**

*- about people in your locality:*

C1	What is the main occupation of the people?	<b>Agricultur e</b>	<b>Others(<i>specify</i>)</b>			
C2	How many people have a house of their own?	<b>Few</b> <input type="checkbox"/>	<b>Many</b> <input type="checkbox"/>	<b>Most</b> <input type="checkbox"/>		
C3	How many people have land of their own?	<b>Few</b> <input type="checkbox"/>	<b>Many</b> <input type="checkbox"/>	<b>Most</b> <input type="checkbox"/>		
C4	How many people have cattle of their own?	<b>Few</b> <input type="checkbox"/>	<b>Many</b> <input type="checkbox"/>	<b>Most</b> <input type="checkbox"/>		
C5	How many people <b>Smoke</b> in your locality?	<b>Few</b> <input type="checkbox"/>	<b>Many</b> <input type="checkbox"/>	<b>Most</b> <input type="checkbox"/>		
C6	How many people consume <b>Alcohol</b> ?	<b>Few</b> <input type="checkbox"/>	<b>Many</b> <input type="checkbox"/>	<b>Most</b> <input type="checkbox"/>		
C7	How many people take <b>Drugs</b> in your locality?	<b>Few</b> <input type="checkbox"/>	<b>Many</b> <input type="checkbox"/>	<b>Most</b> <input type="checkbox"/>		
C8	How many people <b>Gamble</b> in your locality?	<b>Few</b> <input type="checkbox"/>	<b>Many</b> <input type="checkbox"/>	<b>Most</b> <input type="checkbox"/>		
C9	How many people borrow money from money lenders?	<b>Few</b> <input type="checkbox"/>	<b>Many</b> <input type="checkbox"/>	<b>Most</b> <input type="checkbox"/>		
C10	Is domestic violence (husband beating wife etc.) common in your area?	<b>Yes</b> <input type="checkbox"/>		<b>No</b> <input type="checkbox"/>		
C11	How many schools are there in your location and within	<b>None</b>	1	2	3	<b>4 or more</b> <input type="checkbox"/>



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10 km area?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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**D. TRAINING**

D1. Write 1 or 2 incidents in your life or ministry that made you feel that you need this type of training? (Attach more pages if you need)

<b>Fill-up/tick wherever appropriate:</b>					
D2. Have you received any medical/health training in the past?			Yes <input type="checkbox"/>	No <input type="checkbox"/> <b>(If No, Please Do not fill up the section from D3 TO D11)</b>	
D3. If yes, give these details:	a) By whom was the training given?				
	b) For how many days?				
	c) Was it useful?		Yes <input type="checkbox"/>	No <input type="checkbox"/>	
	If yes, Explain how it was useful:-				
D4. Are you presently involved in any medical work in your locality?			Yes <input type="checkbox"/>	No <input type="checkbox"/>	
D5. If yes, give the details:	a) How many patients do you see in a month?	Less than 5 patients <input type="checkbox"/>	5-10 patients <input type="checkbox"/>	10 -20 patients <input type="checkbox"/>	More than 20 <input type="checkbox"/>
	b) Where do you see these patients?	At Your home <input type="checkbox"/>	When visiting villages <input type="checkbox"/>	After church service <input type="checkbox"/>	Other places <input type="checkbox"/> <i>(specify)</i>
	c) How do you get the medicines that you need to give to the patients?				



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	d) How do you supply medicines for the patients?	<b>From your own stock</b> <input type="checkbox"/>	<b>Ask them to buy outside</b> <input type="checkbox"/>		
	e) Do you charge them any money?	<b>for medicine only</b> <input type="checkbox"/>	<b>for your service only</b> <input type="checkbox"/>	<b>For both service &amp; medicine</b> <input type="checkbox"/>	<b>No charge</b> <input type="checkbox"/>
	f) What do you do when you have doubts?				
	g) Where do you refer your patients and how?				
	h) Do you have contact with any doctor with whom you have a good relationship so as to refer your patients	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>		

D6. Do you give any sort of health education to the people in your area?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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D7. Do you feel that you need more skills while treating people who come to you?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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D8. If yes, state what skills will be useful for you?

D9. What are the health related activities you are engaged with presently?

D10. How much time do you spend in a week on health – related activities?

D11. Have you come across any opposition / hindrances when involving yourself with health related activities? Write in detail about 1 or 2 incidents:(attach more pages if you need)



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E. Which diseases among those listed below are seen in your locality?

<i>Please tick the appropriate column:</i>				
No.	Name of Disease	Very Common	Common	Rare
1	Malaria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Typhoid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	TB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Loose motion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	Eye infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Skin problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	Ear Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	Gas Problem/Acidity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	White discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13	Menstrual problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14	Worms in the stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15	Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16	High BP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18	Mental problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19	Malnourished Children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20	AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21	Genital infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22	Fits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23	Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24	Snake bites	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25	Scorpion bites	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26	Dog bites	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27	Other insect/animal bites (specify)			
28	Any other(specify)			
29	Any other(specify)			
30	Any other(specify)			