

**Appendix-i**  
**FORM (pregnant women)**

**General information**

**1. Code:**

**2. Contact no.:**

**3. Address:**

**4. Name:**

**5. Age (y):**

**6. Religion:**

Hindu:      Muslim:      Sikh:      Christian:

**7. Qualification:**

Illiterate:      Primary:      X pass:      XII pass:      Graduate:

**8. Occupation:**

Working:      Housewife:

**9. LMP:**                      **EDD**

**10. Gravida:**              **Parity:**              **Abortion:**              **Live:**

**Dead:**

**11. Type of family:**

Nuclear:      Joint:      Extended:

**12. Total family members:**

2:      3-4:      5-6:      >6:

**13. Total family income (rs.):**

<2,000:      2,000-5,000:      5,000-10,000:      >10,000:

**14. Per capita income:**

**15. Morbidity profile:**

Family member	Type of disease	Duration



### Antenatal Information

1. First antenatal visit (month):

2. Total no. of antenatal visits (month):

3. Abdominal examination:

Trimester I		Trimester II		Trimester III	
3 <sup>rd</sup> M		7 <sup>th</sup> M		9 <sup>th</sup> M	

4. Blood pressure measurement:

Trimester I		Trimester II		Trimester III	
3 <sup>rd</sup> M		7 <sup>th</sup> M		9 <sup>th</sup> M	

5. Weight check-up:

Weight Check-up (kg)	1 <sup>st</sup> Visit	Months					
		4 <sup>th</sup>	5 <sup>th</sup>	6 <sup>th</sup>	7 <sup>th</sup>	8 <sup>th</sup>	9 <sup>th</sup>

6. Iron folic acid supplementation:

Trimester II					
4 <sup>th</sup> M		5 <sup>th</sup> M		7 <sup>th</sup> M	

7. TT injection:

Month			
4 <sup>th</sup>		6 <sup>th</sup>	

8. Intestinal parasite drug:                      Yes-                      No-

9. Information of specific pregnancy complications:

Yes-

No-

Difficulty with vision during daylight-

Night blindness-

Convulsions not from fever-

Swelling of the legs or face-

Excessive fatigue-

Vaginal bleeding-

## **KAP**

### **1. Have you ever heard about iodized salt:**

Yes-                      No-

### **2. Can you recognize iodized salt:**

Yes-                      No-

If yes, how will you recognize?

Smiling sun logo-                      other-

### **3. Do you know the brand name of salt that is used in your family:**

Yes-                      No-                      if yes, specify-

### **4. Cost of salt (per kg):**

2                      3-5                      6-10                      >10

### **5. Amount of salt used in the family (kg):**

1                      2                      >2

### **6. Where do you keep your salt:**

Near flame-                      Away from flame-

### **7. How do you store salt:**

Covered contained-                      Uncovered contained-                      Polythene-

### **8. At what time you add salt during cooking:**

Starting-                      Mid-                      End-

### **9. Have you ever heard about IFA-**

Yes-                      No-

### **10. Are you under any of the services provided by government:**

Yes-                      No-

If no, what are the reasons behind not availing the services?

Not interested-                      not aware-                      cant answer-

### **11. From where do you get supplements:**

Gov. Hospital-                      Private hospital-                      AWC-

### **12. Do you regularly take supplements:**

Yes-                      No-

If yes, how many tablets are provided each time?

<15                      15-30                      >30

Frequency of consuming tablets:

Daily-                      2-3 times a wk-                      weekly-                      once in 15  
days-

If no, what are the reasons behind not taking  
supplements?

Not necessary-                      side effects-                      dislike-                      often  
forget-

**13. Have you faced any side effects after consuming the tablets:**

Yes-                      No-                      If yes, specify-

**14. What do you do in case of side effects:**

Continue-                      Discontinue-                      Reduce the dose-

**15. Have you felt any beneficial change after receiving the  
supplements:**

Yes-                      No-                      if yes, specify-

### **Dietary Information**

**1. Is there any change in your diet patter during pregnancy:**

Yes-                      No-                      if yes, specify-

**2. Any special food items consumed during pregnancy:**

Yes-                      No-                      if yes, specify-

**3. Type of food consumed:**

V-                      NV-                      OV-