

## Baseline questionnaire for TB patients

Participant ID: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Arm <input type="checkbox"/> SAT <input type="checkbox"/> DOT	Health Professional ID: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<b>Demographics</b>				
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Occupation: <input type="checkbox"/> No job <input type="checkbox"/> Housewife <input type="checkbox"/> Student <input type="checkbox"/> Government <input type="checkbox"/> Farmer <input type="checkbox"/> Daily laborer <input type="checkbox"/> Trader <input type="checkbox"/> Other .....	Educational Level: <input type="checkbox"/> None <input type="checkbox"/> Elementary (0-8) <input type="checkbox"/> Secondary (9-10) <input type="checkbox"/> Preparatory (11-12) <input type="checkbox"/> University (Diploma) <input type="checkbox"/> University (≥Degree)		
Age in years: <input type="checkbox"/> <input type="checkbox"/>	Region .....	Zone/Sub-city .....		
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Never <input type="checkbox"/> Divorced <input type="checkbox"/> Widower	Whom you live with? <input type="checkbox"/> Alone <input type="checkbox"/> Family <input type="checkbox"/> Friends <input type="checkbox"/> Homeless <input type="checkbox"/> Other .....	How many people live in the house including you? <input type="checkbox"/> ≤ 3 <input type="checkbox"/> 4-6 <input type="checkbox"/> 7-9 <input type="checkbox"/> ≥ 10	How many bedrooms are in the house? <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> ≥4	
Are you head of the household? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you a permanent or temporary resident in Addis <input type="checkbox"/> Permanent <input type="checkbox"/> Tempo.	What is your average monthly income? .....	Distance from home to this health center ..... KM	
<b>Behavioral</b>				
Smoking cigarettes per day <input type="checkbox"/> Never <input type="checkbox"/> 1-5 <input type="checkbox"/> 6-10 <input type="checkbox"/> >10	Use of Chat: <input type="checkbox"/> Never <input type="checkbox"/> 1/week <input type="checkbox"/> ≥2/week <input type="checkbox"/> 1/month	Drinking alcohol: <input type="checkbox"/> Never <input type="checkbox"/> >1/day; <input type="checkbox"/> 2-5/day <input type="checkbox"/> ≥6/day <input type="checkbox"/> Weekly <input type="checkbox"/> Rarely	Taking cocaine/marijuana <input type="checkbox"/> Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Regularly, <5/day <input type="checkbox"/> Regularly, >5/day	
<b>From TB registration log</b>				
HIV status: <input type="checkbox"/> Pos <input type="checkbox"/> Neg	If HIV+, currently on ARV <input type="checkbox"/> Yes <input type="checkbox"/> No	Weight in Kg .....	Date TB treatment started (DD-MM-YY) .....	
Height in cm .....	.....	.....	.....	
TB treatment status <input type="checkbox"/> new <input type="checkbox"/> relapse	TB tested positive using: <input type="checkbox"/> Microscopy <input type="checkbox"/> Xpert MTB/RIF	If drug susceptibility test done, result <input type="checkbox"/> Susceptible <input type="checkbox"/> Resistant	Place of diagnosis: <input type="checkbox"/> This facility <input type="checkbox"/> Another health center <input type="checkbox"/> Public hospital <input type="checkbox"/> NGO health facility <input type="checkbox"/> Private clinic/ hospital <input type="checkbox"/> Other.....	
Date diagnosed as TB patient .....	If microscopy, result was: <input type="checkbox"/> 1-9(Scanty) <input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+	Have you ever treated		
Have you ever had TB treatment before? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes: Have you completed your previous TB treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No, why .....			
<b>Study clinician signature</b>			<b>Date (Ethiopian calendar):</b>	