CHHIM Study

(Therapeutic Hookworm Phenotyping Study)

Eligibility Questionnaire

Thank you for expressing an interest in participating in our research project. To ensure you are eligible to participate in the research project we would appreciate it if you can answer the following questions.

If you have any comments or questions relating to the research project or the questionnaire please feel free to email **Mali Camberis** on hookworm@malaghan.org.nz .

Name: _____

Email address: _____

Postal address: _____

Day time phone number: _____

General practitioner: _____

Date of birth: _____

Current weight: _____kg **Height**: _____cm

Gender (please tick): Male ☐ Female ☐ Other ☐

Ethnicity (please tick all that apply):

NZ European ☐ Maori ☐ Samoan ☐ Cook Island Maori ☐

Tongan ☐ Indian ☐ Chinese ☐

Other ☐ please specify: _____

Do you smoke cigarettes (please tick)? Yes ☐ No ☐

Do you drink alcohol (please tick)? Yes ☐ No ☐

If yes, how many standard drinks do you consume per week? _____

(1 standard drink is 1 can/bottle of standard beer (330ml), 100ml wine or 30ml of spirits)

If yes, on how many occasions would you drink alcohol per week? _____

Have you been diagnosed with or experienced any of the following (tick for yes)?

	Tick
Heart disease	
Stroke	
High cholesterol	
High blood pressure	
Kidney disease	
Cancer	
Diabetes (type 1 or 2, or prediabetes)	
Inflammatory bowel disease	
Irritable bowel syndrome	
Bowel or gastrointestinal surgery	

Continued…	Tick
Food intolerance or allergies causing diarrhoea, bloating, cramping or constipation	
Long term diarrhoea or constipation	
Autoimmune disease (e.g. Coeliac disease, Rheumatoid arthritis, Multiple sclerosis, Asthma)	
Thyroid condition	
Lung disease	
Liver disease, i.e. Hepatitis C or B	
Other (please specify):	

Have you consumed prebiotic or probiotic yoghurt, or fermented drinks or foods (i.e. Symbio probalance, Bio yoghurt, Yoplait Elivae, Activate, Bio farm organic, Yakult, Kefir, Sauerkraut, Kimchi, Kombucha) **within the <u>past month</u>** (please tick)?

Yes ☐ No ☐

If yes, please specify the product name and frequency of consumption: _____

_____

Have you taken antibiotics within the <u>last 6 months</u> (please tick)?

Yes ☐ No ☐

If yes, please specify the name of the antibiotic and when you last took it:

_____

Are you pregnant or breastfeeding, or planning to become pregnant within the <u>next year</u> (please tick)?

Yes ☐ No ☐

Are you taking any medications (traditional or homeopathic) **or nutritional supplements?**

Type of medication/supplement	**Taking?** (please tick)	**If you have answered <u>YES</u> for any of the medication or supplement options please provide the below information**	
		Medication/supplement name	***Dose and frequency***
Antibiotics	Yes ☐ No ☐		
Blood pressure lowering	Yes ☐ No ☐		
Cholesterol lowering	Yes ☐ No ☐		
Vitamins or minerals	Yes ☐ No ☐		
Laxatives	Yes ☐ No ☐		
Metamucil or Benefibre	Yes ☐ No ☐		
Phloe or Kiwicrush	Yes ☐ No ☐		
Probiotics	Yes ☐ No ☐		
Prebiotics	Yes ☐ No ☐		
Antacids or anti-reflux	Yes ☐ No ☐		
Steroids	Yes ☐ No ☐		
Anti-inflammatory	Yes ☐ No ☐		
Other	Yes ☐ No ☐		
Other	Yes ☐ No ☐		

Has your weight been stable over the <u>last 6 months</u> (please tick)? Yes ☐ No ☐

If no, please record the amount of weight you have lost or gained? _____kg

Have you ever been infected with a hookworm, tapeworm, fluke or nematode (i.e. parasitic worm) (please tick)? Yes ☐ No ☐

Have you participated in any other research projects and/or receive any investigational medications or devices within the last month (please tick)?

Yes ☐ No ☐

Have you made any significant changes to your food intake (i.e. become vegetarian/vegan, stopped consuming gluten, dairy or sugar, increased your fruit and vegetable intake or increased/decrease the amount of food you are eating) **over the last 6 months** (please tick)? Yes ☐ No ☐

If yes, what changes to your food intake have you made?

_____

_____

Do you regularly experience any of the following (please tick all that apply)?

Abdominal pain ☐ Abdominal bloating ☐

Flatulence/wind ☐

If you experience abdominal pain, bloating or flatulence/wind is it mild (nagging/annoying)**, moderate** (strong negative influence on your daily living) **or severe** (disabling) (please tick the boxes that apply)?

	Absent	**Mild**	**Moderate**	**Severe**
Abdominal pain				
Abdominal bloating				
Flatulence/wind				