OMB#: 0925-xxxx EXP. DATE xx/xx/xxxx

DIET AND HEALTH STUDY

NATIONAL INSTITUTES OF HEALTH AND AARP

NIH–AARP Diet and Health Study
Short Questionnaire

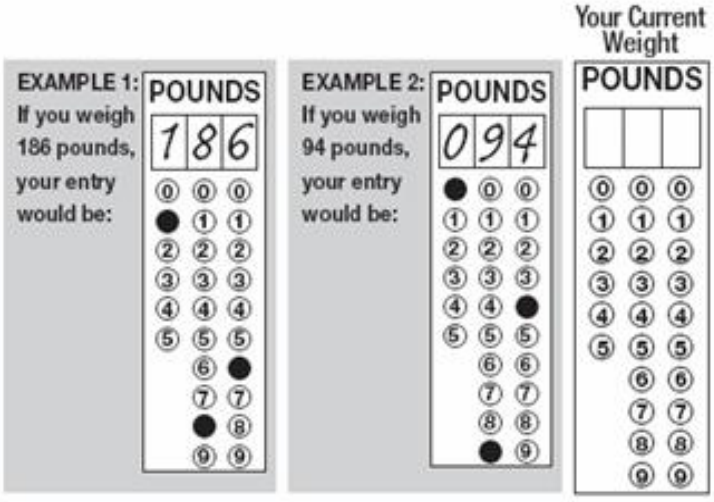
GENERAL INSTRUCTIONS

Answer to the best of your ability, rather than leaving a response blank.

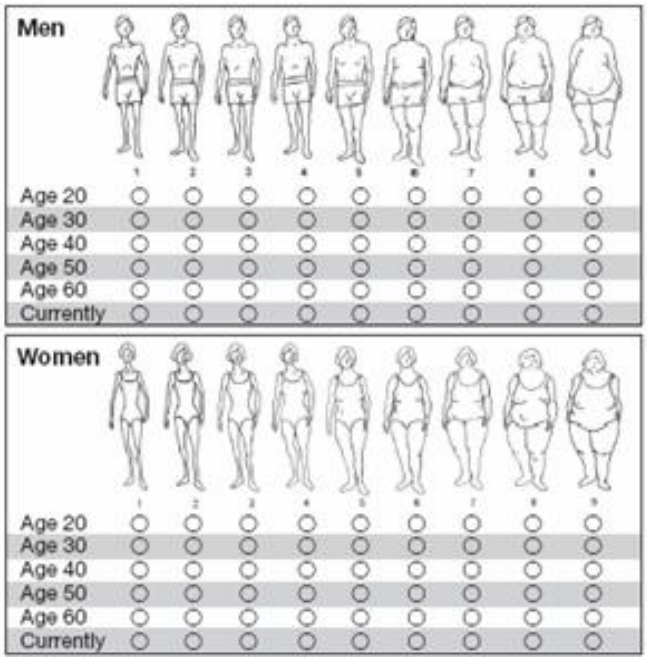
Be certain to *completely blacken* in each of your answers and do not make any stray marks.

CORRECT MARK: ● **INCORRECT MARKS:** ✓ ✗ ◒ ◔

1. What is your current weight in pounds? *(Enter your current weight and mark one circle beneath each box.)*



2. For each of the ages shown below, select the diagram that best describes your body shape at that age. *(Mark one circle at each age.)*



3. How many times a week do you usually do **30 minutes of moderate physical activity** or walking that increases your heart rate or makes you breathe harder than normal? *(For example, brisk walking, bicycling at a regular pace, carrying light loads, mowing the lawn, or playing doubles tennis.)*

○ None ○ 1–2 times/week ○ 3–4 times/week ○ 5 or more times/week

4. How many times a week do you usually do **20 minutes of vigorous physical activity** that makes you sweat or puff and pant? *(For example, jogging, aerobics, weight training or lifting, or fast bicycling.)*

○ None ○ 1–2 times/week ○ 3–4 times/week ○ 5 or more times/week

PLEASE TURN OVER ☞

5. Do you currently smoke cigarettes?

○ No ○ Yes ☞ How many cigarettes/day? ○ 1–10 ○ 11–20 ○ 21–40 ○ 41 or more

6. Have you ever been told by a doctor that you had any of the following conditions? *(Please mark one circle to indicate the year that you were first diagnosed.)*

Condition (First Diagnosed)	No	YES—YEAR CONDITION WAS FIRST DIAGNOSED *(Mark only one response per condition.)* Before 2004	2004–2005	2006–Present
High blood pressure	○	○	○	○
Diabetes	○	○	○	○
High cholesterol	○	○	○	○
Heart attack, angina, or coronary artery disease	○	○	○	○
TIA (Transient Ischemic Attack)	○	○	○	○
Stroke	○	○	○	○
Pulmonary embolus (blood clot in lungs)	○	○	○	○
COPD (Chronic Obstructive Pulmonary Disease)	○	○	○	○
Emphysema or chronic bronchitis	○	○	○	○
Hip fracture	○	○	○	○
Macular degeneration of the eye	○	○	○	○
Kidney stones	○	○	○	○
Gallstones	○	○	○	○
Colon or rectal polyps	○	○	○	○
Stomach or duodenal ulcer	○	○	○	○
Parkinson's disease	○	○	○	○
Multiple sclerosis	○	○	○	○
ALS (Amyotrophic lateral sclerosis, Lou Gehrig's Disease)	○	○	○	○
Depression	○	○	○	○
Cancer (any type)	○	○	○	○

7. Have you ever had any of the following procedures performed? *(Please mark one circle to indicate the year that you were first performed.)*

	No	YES—YEAR FIRST PERFORMED *(Mark only one response per procedure.)* Before 2004	2004–2005	2006–Present
Coronary angioplasty	○	○	○	○
Coronary artery bypass	○	○	○	○
Gallbladder removal	○	○	○	○
Hip replacement	○	○	○	○

MEN ONLY

8. When did you last have a PSA test (a test that screens your blood for indications of prostate cancer)? *(Mark only one circle.)*

○ Never had one ○ Less than 1 year ago ○ 1–2 years ago ○ 3–4 years ago
○ 5 or more years ago ○ Had one, but not sure when ○ Not sure if had one

WOMEN ONLY

9. Have you had your uterus removed, that is, have you had a hysterectomy?

○ No ○ Yes ☞ Date of surgery: ○ Before 2004 ○ 2004–2005 ○ 2006–present

10. Have you had either of your ovaries surgically removed?

○ No ○ Yes ☞ Date of most recent surgery: ○ Before 2004 ○ 2004–2005 ○ 2006–present
☞ How many ovaries do you have remaining? ○ None ○ One

THANK YOU!

Please return the completed questionnaire in the pre-paid envelope to: XXXX XXXX XXXX