

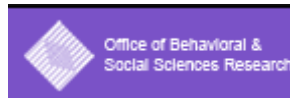
**Attachment 4**  
**Data Collection Instruments**

# PHYSICIAN SURVEY OF PRACTICES ON DIET, PHYSICAL ACTIVITY, AND WEIGHT CONTROL: *ADULT QUESTIONNAIRE*

Conducted by:



National Institute of  
Diabetes & Digestive &  
Kidney Diseases



National Institute of Child Health  
and Human Development (NICHD)



Department of Health and Human Services

Centers for Disease Control and Prevention

Public reporting burden for this response is estimated to be an average of xx minutes per questionnaire including time for reviewing instructions. Send comments regarding this burden statement or any other aspect of this collection of information including suggestions for reducing this burden to XXXXXXXXX. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0925-xxxx.

## INTRODUCTION

The Physician Survey of Practices on Diet, Physical Activity, and Weight Control – *Adult Questionnaire* is sponsored by the National Cancer Institute in collaboration with The Office of Behavioral and Social Science Research, National Institute of Child Health and Human Development, the National Institute of Diabetes and Digestive and Kidney Diseases, and the Centers for Disease Control and Prevention. It is being sent to a random sample of Family Medicine Physicians, General Internists, Obstetrician/Gynecologists, and Pediatricians. Your name and contact information were provided to us by the American Medical Association.

This survey asks about the evaluation and guidance you provide to your patients about diet, weight, and physical activity.

The information you provide will remain confidential to the fullest extent of the law. Your answers will be aggregated with those of other respondents in reports to NCI and any other parties.

Participation is voluntary, and there are no penalties to you for not responding. However, not responding could seriously affect the accuracy of final results, and your point of view may not be adequately represented in the survey findings.

## INSTRUCTIONS

- When you answer, include ALL the patients you treat in the age range specified.
- Answer the questions regarding your main primary care practice location (i.e., the practice setting where you spend the most hours per week, at which the majority of your patients are seen.)
- Use an X or check mark in the box to indicate your answers.
- Use the line provided in “Other (specify): \_\_\_\_\_” if your answer is not adequately represented by available choices

Physician Survey of Practices on Diet, Physical Activity, and Weight Control:  
Adult Questionnaire

**SECTION A: PATIENT POPULATIONS TREATED**

**A1. Please indicate the patient population(s) you treat.**

**CHECK ONE IN EACH ROW**

	<b>YES</b>	<b>NO</b>
a. Do you see infants, < 2 years?	<input type="checkbox"/>	<input type="checkbox"/>
b. Do you see children 2-11 years?	<input type="checkbox"/>	<input type="checkbox"/>
c. Do you see adolescents 12-17 years?	<input type="checkbox"/>	<input type="checkbox"/>
d. Do you see adults 18-65 years?	<input type="checkbox"/>	<input type="checkbox"/>
e. Do you see older adults 65+ years?	<input type="checkbox"/>	<input type="checkbox"/>

**THOUGH YOU MAY TREAT A WIDE RANGE OF PATIENTS, THE  
FOLLOWING QUESTIONS FOCUS ON ADULT POPULATIONS YOU  
TREAT, AGE 18 YEARS AND OLDER.**

**Physician Survey of Practices on Diet, Physical Activity, and Weight Control:  
Adult Questionnaire**

The next questions are about practices involving adult patients 18 years and older.

**A2. During routine well-patient physical exams of your adult (18 years and older) patients:**

CHECK ONE IN EACH ROW

	NEVER	RARELY	SOMETIMES	OFTEN	ALWAYS
a. How often do you <u>assess</u> diet, or physical activity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. As a general policy, for your entire adult patient population, how often do you promote:					
Healthy Diet / Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**A3. For your adult patients WITHOUT weight-related chronic disease who have an unhealthy diet, are insufficiently active, or are overweight:**

**How often do you...:**

CHECK ONE IN EACH ROW

	NEVER	RARELY	SOMETIMES	OFTEN	ALWAYS
a. Provide <u>general counseling</u> for changing diet, physical activity, or weight?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Provide <u>specific guidance</u> on:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diet/Nutrition (e.g. "Eat more fruits and vegetables" or "Increase your calcium")?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Activity (e.g. "Increase your exercise by walking daily")?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight Control (e.g. "Lose <u>X</u> lbs by cutting calories and exercising")?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. <u>Refer</u> these patients to another health professional or program outside of your practice for further evaluation and/or management?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Systematically <u>track/follow</u> patients over time concerning behaviors or other measures of progress related to diet, physical activity, or weight?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Physician Survey of Practices on Diet, Physical Activity, and Weight Control:  
Adult Questionnaire**

**A4. For your adult patients WITH weight-related chronic disease who have an unhealthy diet, are insufficiently active, or are overweight:**

**How often do you...:**

**CHECK ONE IN EACH ROW**

	NEVER	RARELY	SOMETIMES	OFTEN	ALWAYS
a. Provide <u>general counseling</u> for changing diet, physical activity, or weight?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Provide <u>specific guidance</u> on:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diet/Nutrition (e.g. "Eat more fruits and vegetables" or "Increase your calcium")?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Activity (e.g. "Increase your exercise by walking daily")?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight Control (e.g. "Lose <u>X</u> lbs by cutting calories and exercising")?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. <u>Refer</u> these patients to another health professional or program outside of your practice for further evaluation and/or management?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Systematically <u>track/follow</u> patients over time concerning behaviors or other measures of progress related to diet, physical activity, or weight?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**A5. If you assess diet, HOW do you assess it?**

Not applicable. I do not assess diet. **GO TO A6.**

**CHECK ONE IN EACH ROW**

	YES	NO
a. <u>General</u> questions about food groups (e.g., fruits and vegetables)	<input type="checkbox"/>	<input type="checkbox"/>
b. <u>General</u> questions about dietary patterns (e.g., fast food)	<input type="checkbox"/>	<input type="checkbox"/>
c. <u>Specific</u> questions about diet components (e.g., calcium, protein)	<input type="checkbox"/>	<input type="checkbox"/>
d. Standardized diet questionnaire	<input type="checkbox"/>	<input type="checkbox"/>
e. Other (Please specify) _____	<input type="checkbox"/>	<input type="checkbox"/>



**Physician Survey of Practices on Diet, Physical Activity, and Weight Control:  
Adult Questionnaire**

**A8. How often are the following tests utilized in your practice for overweight/obese adult patients?**

CHECK ALL THAT APPLY

	<b>Not Applicable (Do not utilize)</b>	<b>Every 2 years</b>	<b>Annually</b>	<b>Every 6 months</b>	<b>More than twice a year</b>	<b>Other (Specify):</b>
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a. Random blood glucose

Patients <b><u>with</u></b> additional risk factors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
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Patients <b><u>without</u></b> additional risk factors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
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b. Fasting blood glucose

Patients <b><u>with</u></b> additional risk factors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
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Patients <b><u>without</u></b> additional risk factors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
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**A9. Have you ever, or are you currently...**

CHECK **TWO** FOR EACH ROW

	<b>EVER</b>		<b>CURRENTLY</b>	
	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>

a. Prescribing pharmacological treatments for weight control to any of your patients?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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b. Referring any of your patients for surgical treatment for obesity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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**Physician Survey of Practices on Diet, Physical Activity, and Weight Control:  
Adult Questionnaire**

**A10. When you treat each of the following conditions, do you address diet/nutrition, physical activity or weight control?**

	CHECK ALL THAT APPLY			
	Do Not Treat this Condition	Diet	Physical Activity	Weight Control
a. Abnormal body weight/BMI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Abnormal lipid profile	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Eating disorders such as anorexia or bulimia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Diabetes mellitus (Type II)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Coronary heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Sleep apnea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Chronic obstructive lung disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Back pain/problems/injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Family history of diabetes mellitus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Family history of heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. Family history of cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p. Other, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Physician Survey of Practices on Diet, Physical Activity, and Weight Control:  
Adult Questionnaire

**SECTION B: BARRIERS TO PATIENT ASSESSMENT,  
EVALUATION, and MANAGEMENT**

**B1. Which of the following are the TOP 3 BARRIERS to evaluating and/or managing your patients' diet/nutrition, physical activity, and weight in your practice?**

**CHECK THE TOP 3 BARRIERS**

- |   |                          |
|---|--------------------------|
| a. Not enough time  | <input type="checkbox"/> |
| b. Not part of my role  | <input type="checkbox"/> |
| c. I am not adequately trained in this area   | <input type="checkbox"/> |
| d. Too difficult to evaluate and manage   | <input type="checkbox"/> |
| e. Inadequate reimbursement   | <input type="checkbox"/> |
| f. Lack of adequate referral services for diet, physical activity and weight                | <input type="checkbox"/> |
| g. Patients are not interested in improving their diet, physical activity, or weight levels | <input type="checkbox"/> |
| h. Fear of offending the patient  | <input type="checkbox"/> |
| i. Too difficult for patients to change their behavior                                      | <input type="checkbox"/> |
| j. Lack of effective tools and information to give to patients.                             | <input type="checkbox"/> |
| k. Lack of effective treatment options  | <input type="checkbox"/> |
| l. Other (specify): _____   | <input type="checkbox"/> |

**Physician Survey of Practices on Diet, Physical Activity, and Weight Control:  
Adult Questionnaire**

**B2. Relative to your current practice, what are the TOP 3 improvements that could assist you in reducing patients' health issues related to diet, physical activity, and weight?**

**CHECK THE TOP 3 IMPROVEMENTS**

- a. Ways to more easily **identify** problems with diet, physical activity, and weight
- b. Easy-to-understand patient management **guidelines**
- c. Better **reimbursement** for counseling
- d. Better **tools to communicate** diet, physical activity, or weight problems to patient or family
- e. Better **counseling tools** to guide patients toward lifestyle modification
- f. More **training** for your **staff** in evaluating and managing patient diet, physical activity, and weight
- g. More **training** for **you** in evaluating and managing patient diet, physical activity, and weight
- h. Better **information systems** to **document and track goals** in the medical record
- i. Better **information systems** to identify appropriate **referral services**
- j. Better mechanism to connect patient to specific referral services
- k. Other (specify): \_\_\_\_\_

**Physician Survey of Practices on Diet, Physical Activity, and Weight Control:  
Adult Questionnaire**

**PERSONAL BELIEFS**

**B3. Please indicate how strongly you agree with each of the following statements.**

**CHECK ONE IN EACH ROW**

	<b>Strongly Disagree</b>	<b>Disagree Somewhat</b>	<b>Neither Agree nor Disagree</b>	<b>Agree Somewhat</b>	<b>Strongly Agree</b>
a. Physicians have a responsibility to promote the following with their patients:					
eat a healthy diet.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
be adequately physically active.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
maintain a healthy weight or lose weight.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Patients are more likely to adopt healthier lifestyles if physicians counsel them to do so.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. There are effective strategies and/or tools to help patients:					
eat a healthy diet.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
be adequately physically active.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
maintain a healthy weight or lose weight.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. I am confident in my ability to counsel my patients:					
eat a healthy diet.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
to be adequately physically active.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
maintain a healthy weight or lose weight.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. I am effective at helping my patients					
eat a healthy diet.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
be adequately physically active.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
maintain a healthy weight or lose weight.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. In order to effectively encourage patient adherence to a healthy lifestyle, a physician must adhere to one him/herself.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Specifically, a physician will be able to provide more credible and effective counseling if he/she:					
eats a healthy diet.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
is adequately physically active.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
maintains a healthy weight or loses weight.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Physician Survey of Practices on Diet, Physical Activity, and Weight Control:  
Adult Questionnaire**

**B4. According to current guidelines, at what BMI level are adult patients (18 years or older) considered to be...**

	<b>CHECK <u>ONE</u> IN EACH ROW</b>				
	$\geq 20 \text{ kg/m}^2$	$\geq 25 \text{ kg/m}^2$	$\geq 30 \text{ kg/m}^2$	$\geq 35 \text{ kg/m}^2$	Don't Know
a. Overweight?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Obese?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**B5. According to current guidelines, in what BMI percentile range are children or adolescents (2-17 years) considered to have healthy weight? CHECK ONE**

<input type="checkbox"/>	5 <sup>th</sup> - 65 <sup>th</sup> percentile
<input type="checkbox"/>	5 <sup>th</sup> - 75 <sup>th</sup> percentile
<input type="checkbox"/>	5 <sup>th</sup> - 85 <sup>th</sup> percentile
<input type="checkbox"/>	5 <sup>th</sup> - 95 <sup>th</sup> percentile
<input type="checkbox"/>	Other, specify _____
<input type="checkbox"/>	DON'T KNOW

**B6. According to current guidelines, for adults, 18 and older, how much moderate physical activity is recommended (on most days of the week) for general health and prevention of chronic diseases? CHECK ONE**

<input type="checkbox"/>	20 minutes
<input type="checkbox"/>	30 minutes
<input type="checkbox"/>	40 minutes
<input type="checkbox"/>	60 minutes
<input type="checkbox"/>	90 minutes
<input type="checkbox"/>	Other, specify _____
<input type="checkbox"/>	DON'T KNOW

**Physician Survey of Practices on Diet, Physical Activity, and Weight Control:  
Adult Questionnaire**

**B7. According to current guidelines, for adults, 18 and older, how many servings of fruits and vegetables should a person have in a day? CHECK ONE**

3 servings

5 servings

7 servings

It depends on daily calorie intake

Other, specify \_\_\_\_\_

DON'T KNOW



Physician Survey of Practices on Diet, Physical Activity, and Weight Control:  
Adult Questionnaire

Physical Activity

C3. Moderate physical activities make you breathe somewhat harder than normal. During the last 7 days, did you do any moderate physical activities for at least 10 minutes? Think about activities such as bicycling, swimming, brisk walking, dancing or gardening.

NO → GO TO C4

YES



a. On how many of the past 7 days did you do moderate physical activities? \*

|\_\_| DAYS

b. In the past 7 days, on a typical day in which you did moderate physical activities, how much time did you spend doing them? \*

|\_\_|\_\_|\_\_| MINUTES PER DAY

C4. Vigorous activities make you breathe much harder than normal. Now think about vigorous activities you did that take hard physical effort, such as aerobics, running, soccer, fast bicycling, or fast swimming. During the last 7 days, did you do any vigorous physical activities in your free time for at least 10 minutes?

NO → GO TO C5

YES



a. On how many of the past 7 days did you do vigorous physical activities?

|\_\_| DAYS

b. In the past 7 days, on a typical day in which you did vigorous physical activities, how much time did you spend doing them?

|\_\_|\_\_|\_\_| MINUTES PER DAY

C5. Now think about activities specifically designed to STRENGTHEN your muscles, such as lifting weights or other strength-building exercises. Include all such activities even if you have included them before. During the last 7 days, did you do activities to strengthen your muscles?

NO → GO TO C6

YES



Physician Survey of Practices on Diet, Physical Activity, and Weight Control:  
Adult Questionnaire

Height and Weight Status

C6. How tall are you without shoes?

|\_| FEET |\_|\_| INCHES

IF YOU ARE FEMALE AND CURRENTLY PREGNANT, GO TO C7a.  
OTHERWISE GO TO C7.

C7. How much do you weigh without shoes?

|\_|\_|\_| POUNDS

C7a. If you are currently pregnant, how much did you weigh before your pregnancy?

|\_|\_|\_| POUNDS

C8. Are you currently trying to: CHECK ONE

Lose weight

Gain weight

Maintain weight

Not trying to make a change

Physician Survey of Practices on Diet, Physical Activity, and Weight Control:  
Adult Questionnaire

**PHYSICIAN CHARACTERISTICS**

C9. When were you born?

| 1 | 9 | \_ | \_ | YEAR

C10. Are you... CHECK ONE

Female

Male

C11. Do you consider yourself to be Hispanic or Latino/a? CHECK ONE

YES

NO

C12. What do you consider to be your race? CHECK ONE OR MORE

American Indian or Alaska Native

Asian

Black or African American

Native Hawaiian or Other Pacific Islander

White

C13. During a typical month, approximately what percent of your professional time do you spend in the following activities?

Percent of professional time

a. Providing Primary Care \_\_\_\_\_ %

b. Providing Subspecialty Care \_\_\_\_\_ %  
Please specify: \_\_\_\_\_

c. Research \_\_\_\_\_ %

d. Teaching \_\_\_\_\_ %

e. Administration \_\_\_\_\_ %

f. Other (*specify*): \_\_\_\_\_ %

**TOTAL**

**1 0 0 %**

Physician Survey of Practices on Diet, Physical Activity, and Weight Control:  
Adult Questionnaire

**PRACTICE CHARACTERISTICS**

**C14. Which of the following categories best describes your main primary care practice location? Are you a...**

**CHECK ALL THAT APPLY**

- a. Full- or part-owner of a physician practice
- b. Employee of a physician-owned practice
- c. Employee of a large medical group or health care system
- d. Employee of a staff or group model HMO
- e. Employee of a university hospital or clinic
- f. Employee of a hospital or clinic not associated with a university (including community health clinics)
- g. Other (specify): \_\_\_\_\_

**C15. Please estimate the number of patient visits that you have in a TYPICAL WEEK, EXCLUDING patient visits while on-call (on-call is defined as time outside of regularly scheduled clinical activity):**

\_\_\_\_|\_\_\_\_|\_\_\_\_| Number of Patient Visits

DON'T KNOW

**C16. Approximately what percentage of the patients you treat is female?**

\_\_\_\_|\_\_\_\_|\_\_\_\_| %

DON'T KNOW

**C17. Approximately what percentage of the patients you treat is Hispanic or Latino?....(PLEASE GIVE YOUR BEST ESTIMATE)**

**CHECK ONE**

- a. 0-5%
- b. 6-25%
- c. 26-50%
- d. 51-75%
- e. 76-100%
- f. DON'T KNOW

**Physician Survey of Practices on Diet, Physical Activity, and Weight Control:  
Adult Questionnaire**

**C18. Approximately what percentage of the patients you treat is....(PLEASE GIVE YOUR BEST ESTIMATE)**

	PERCENTAGE OF PATIENTS
a. White	___ ___ ___ %
b. Black or African-American	___ ___ ___ %
c. Asian	___ ___ ___ %
d. Native Hawaiian or Other Pacific Islander	___ ___ ___ %
e. American Indian or Alaska Native	___ ___ ___ %
<b>T O T A L</b>	<b>1 0 0 %</b>

**C19. Within a practice, there may be multiple clinical sites at which medical care is delivered.**

CHECK ONE

**Does this practice have more than one clinical site?**       YES       NO

**C20. About how many physicians, nurse practitioners, and physician assistants provide care in all of the clinical sites within this practice? CHECK ONE**

- 1
- 2 – 5
- 6 – 20
- More than 20 and fewer than 100
- More than 100
- DON'T KNOW

**C21. If this survey were available on the Internet as a web-based questionnaire, would you prefer to fill it out online, or is a paper and pencil survey more convenient for you?**

CHECK ONE

- I prefer paper and pencil
- I prefer a web-based questionnaire
- I have no preference
- Other (please specify): \_\_\_\_\_

**Physician Survey of Practices on Diet, Physical Activity, and Weight Control:  
Adult Questionnaire**

**C22. We would like to obtain additional information about aspects of the practice that support disease prevention activities. However, we know your time is limited, so we'd like to send your office administrator a short questionnaire of about 20 questions related to the structure of your practice and the roles of different staff that work there. Please give us the name of your office administrator, or indicate whether it would be better for us to send the brief questionnaire to you.**

**Check one:**  Dr.           Mr.           Ms.           Mrs.

**First Name:** |\_|\_|\_|\_|\_|\_|\_|\_|\_|

**Last Name:** |\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|

**The office administrator in my practice is less familiar with the clinical roles of my staff; I am the best person to answer questions about my practice.**

**If you have any comments about the questionnaire, individual questions, or the burden, please make them here. We appreciate your participation and feedback.**

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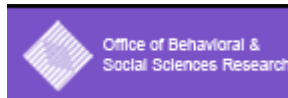
# PHYSICIAN SURVEY OF PRACTICES ON DIET, PHYSICAL ACTIVITY, AND WEIGHT CONTROL

## CHILD/ADOLESCENT QUESTIONNAIRE

Conducted by:



National Institute of  
Diabetes & Digestive &  
Kidney Diseases



National Institute of Child Health  
and Human Development (NICHD)



Department of Health and Human Services

Centers for Disease Control and Prevention

Public reporting burden for this response is estimated to be an average of xx minutes per questionnaire including time for reviewing instructions. Send comments regarding this burden statement or any other aspect of this collection of information including suggestions for reducing this burden to XXXXXXXXX. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0925-xxxx.

## INTRODUCTION

The Physician Survey of Practices on Diet, Physical Activity, and Weight Control – Child/Adolescent Questionnaire is sponsored by the National Cancer Institute in collaboration with The Office of Behavioral and Social Science Research, National Institute of Child Health and Human Development, the National Institute of Diabetes and Digestive and Kidney Diseases and the Centers for Disease Control and Prevention. It is being sent to a random sample of Family Medicine Physicians, General Internists, Obstetrician/Gynecologists, and Pediatricians. Your name and contact information were provided to us by the American Medical Association.

This survey asks about the evaluation and guidance you provide to your patients about diet, weight, and physical activity.

The information you provide will remain confidential to the fullest extent of the law. Your answers will be aggregated with those of other respondents in reports to NCI and any other parties.

Participation is voluntary, and there are no penalties to you for not responding. However, not responding could seriously affect the accuracy of final results, and your point of view may not be adequately represented in the survey findings.

## INSTRUCTIONS

- When you answer, include ALL the patients you treat in the age range specified.
- Answer the questions regarding your main primary care practice location (i.e., the practice setting where you spend the most hours per week, at which the majority of your patients are seen.)
- Use an X or check mark in the box to indicate your answers.
- Use the line provided in “Other (specify): \_\_\_\_\_” if your answer is not adequately represented by available choices

**SECTION A: PATIENT POPULATIONS TREATED**

A1. Please indicate the patient population(s) you treat.

CHECK ONE IN EACH ROW

	YES	NO
a. Do you see infants, < 2 years?	<input type="checkbox"/>	<input type="checkbox"/>
b. Do you see children 2-11 years?	<input type="checkbox"/>	<input type="checkbox"/>
c. Do you see adolescents 12-17 years?	<input type="checkbox"/>	<input type="checkbox"/>
d. Do you see adults 18-65 years?	<input type="checkbox"/>	<input type="checkbox"/>
e. Do you see older adults 65+ years?	<input type="checkbox"/>	<input type="checkbox"/>

**Though you may treat a wide range of patients, this survey focuses on your practices involving your child/adolescent patients (age 2-17).**



The next questions are about practices involving child/adolescent patients (age 2-17).

**A2. During routine well-patient physical exams of your child/adolescent patients (age 2-17):**

CHECK ONE IN EACH ROW

NEVER RARELY SOMETIMES OFTEN ALWAYS

a. How often do you assess diet, or physical activity?

b. As a general policy for your entire child/adolescent patient population, how often do you promote:

Healthy Diet / Nutrition?

Physical Activity?

**A3. For your child/adolescent patients who have unhealthy diet, are insufficiently active, are overweight, or are at risk for weight-related chronic disease:**

CHECK ONE IN EACH ROW

NEVER RARELY SOMETIMES OFTEN ALWAYS

a. How often do you provide general counseling for changing diet, physical activity, or weight?

b. How often do you provide specific guidance on:

Diet/Nutrition (e.g. "Eat more fruits and vegetables" or "Increase your calcium")?

Physical Activity (e.g. "Increase your exercise by walking daily")?

Weight Control (e.g. "Lose X lbs by cutting calories and exercising")?

c. How often do you refer these patients to another health professional or program outside of your practice for further evaluation and/or management?

d. How often do you systematically track/follow patients over time concerning behaviors or other measures of progress related to diet, physical activity, or weight?

**A4. When you assess diet in patients 2-17 years, HOW do you assess it?**

Not applicable. I do not assess diet. **GO TO A5**

**CHECK ONE IN EACH ROW**

YES NO

- |   |                          |                          |
|---|--------------------------|--------------------------|
| a. <u>General</u> questions about food groups (e.g., fruits and vegetables) | <input type="checkbox"/> | <input type="checkbox"/> |
| b. <u>General</u> questions about dietary patterns (e.g., fast food)        | <input type="checkbox"/> | <input type="checkbox"/> |
| c. <u>Specific</u> questions about diet components (e.g., calcium, protein) | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Standardized diet questionnaire  | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Other (Please specify) _____   | <input type="checkbox"/> | <input type="checkbox"/> |

**A5. When you assess physical activity in patients 2-17 years, HOW do you assess it?**

Not applicable. I do not assess physical activity. **GO TO A6**

**CHECK ONE IN EACH ROW**

YES NO

- |   |                          |                          |
|---|--------------------------|--------------------------|
| a. General questions about amount of physical activity                                | <input type="checkbox"/> | <input type="checkbox"/> |
| b. <u>General</u> questions about amount of sedentary activity (e.g. TV watching)     | <input type="checkbox"/> | <input type="checkbox"/> |
| c. <u>Specific</u> questions about duration, intensity, and type of physical activity | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Standardized physical activity questionnaire                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Other (Please specify) _____   | <input type="checkbox"/> | <input type="checkbox"/> |

Physician Survey of Practices on Diet, Physical Activity, and Weight Control  
Child/Adolescent Questionnaire

**A6. How often do you assess or review the following in children or adolescents (ages 2-17)?**

CHECK ALL THAT APPLY

	Every well patient visit	Every visit	Annually	As clinically indicated	Never	Other interval (Specify)
a. Weight measured in office	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
b. Height measured in office	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
c. Body Mass Index	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
d. Waist circumference or waist-to-hip ratio	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
e. Weight-for-age growth charts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
f. Stature-for-age growth charts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
g. BMI-for-age growth chart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

**A7. How often do you assess or review the following in infants (ages <2)?**

CHECK ALL THAT APPLY

	Every well patient visit	Every visit	Annually	As clinically indicated	Never	Other interval (Specify)
a. Weight measured in office	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
b. Length measured in office	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
c. Growth chart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
d. Weight-for-length growth charts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
e. Weight-for-age growth charts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
f. Length-for-age growth chart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Physician Survey of Practices on Diet, Physical Activity, and Weight Control  
Child/Adolescent Questionnaire

**A8. For your overweight/obese child/adolescent patients (ages 2-17), at what age do you begin performing the following tests?**

If you DO NOT perform these tests, please check "N/A".

CHECK ONE IN EACH ROW

N/A                      Age in Years

a. **Random blood glucose testing**

Patients **with** risk factors or family history                                            \_\_\_\_\_

Patients **without** risk factors or family history                                            \_\_\_\_\_

b. **Fasting blood glucose testing**

Patients **with** risk factors or family history                                            \_\_\_\_\_

Patients **without** risk factors or family history                                            \_\_\_\_\_

**A9. How often are the following tests utilized in your practice for overweight/obese children/adolescent patients (ages 2-17)?**

If you DO NOT perform these tests, please check "N/A".

CHECK ALL THAT APPLY

	N/A	Every 2 years	Annually	Every 6 months	More than twice a year	Other (Specify):
--	-----	---------------------	----------	----------------------	---------------------------------	---------------------

a. **Random blood glucose**

Patients **with** additional risk factors                                                                                                                                    \_\_\_\_\_

Patients **without** additional risk factors                                                                                                                                    \_\_\_\_\_

b. **Fasting blood glucose**

Patients **with** additional risk factors                                                                                                                                    \_\_\_\_\_

Patients **without** additional risk factors                                                                                                                                    \_\_\_\_\_

Physician Survey of Practices on Diet, Physical Activity, and Weight Control  
 Child/Adolescent Questionnaire

**A10. When you treat each of the following conditions for your child/adolescent patients (ages 2-17), do you address diet/nutrition, physical activity or weight control?**

	Do Not Treat this Condition	CHECK <u>ALL</u> THAT APPLY		
		Diet	Physical Activity	Weight Control
a. Abnormal body weight/BMI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Elevated blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Abnormal lipid profile	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Eating disorders such as anorexia or bulimia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Diabetes mellitus (Type II)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Family history of diabetes mellitus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Family history of heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Family history of cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Other, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**SECTION B: BARRIERS TO PATIENT ASSESSMENT, EVALUATION, and MANAGEMENT**

**B1. Which of the following are the TOP 3 BARRIERS to evaluating and/or managing your patients' diet/nutrition, physical activity, and weight in your practice?**

**CHECK THE TOP 3 BARRIERS**

- |   |                          |
|---|--------------------------|
| a. Not enough time  | <input type="checkbox"/> |
| b. Not part of my role  | <input type="checkbox"/> |
| c. I am not adequately trained in this area   | <input type="checkbox"/> |
| d. Too difficult to evaluate and manage   | <input type="checkbox"/> |
| e. Inadequate reimbursement   | <input type="checkbox"/> |
| f. Lack of adequate referral services for diet, physical activity and weight                | <input type="checkbox"/> |
| g. Patients are not interested in improving their diet, physical activity, or weight levels | <input type="checkbox"/> |
| h. Fear of offending the patient  | <input type="checkbox"/> |
| i. Too difficult for patients to change their behavior                                      | <input type="checkbox"/> |
| j. Lack of effective tools and information to give to patients.                             | <input type="checkbox"/> |
| k. Lack of effective treatment options  | <input type="checkbox"/> |
| l. Other (specify): _____   | <input type="checkbox"/> |

**B2. Relative to your current practice, what are the TOP 3 improvements that could assist you in reducing patients' health issues related to diet, physical activity, and weight?**

**CHECK THE TOP 3 IMPROVEMENTS**

a. Ways to more easily **identify** problems with diet, physical activity, and weight

b. Easy-to-understand patient management **guidelines**

c. Better **reimbursement** for counseling

d. Better **tools to communicate** diet, physical activity, or weight problems to patient or family

e. Better **counseling tools** to guide patients toward lifestyle modification

f. More **training** for your **staff** in evaluating and managing patient diet, physical activity, and weight

g. More **training** for **you** in evaluating and managing patient diet, physical activity, and weight

h. Better **information systems** to **document and track goals** in the medical record

i. Better **information systems** to identify appropriate **referral services**

j. Better mechanism to connect patient to specific referral services

k. Other (specify): \_\_\_\_\_

**PERSONAL BELIEFS**

**B3. Please indicate how strongly you agree with each of the following statements.**

**CHECK ONE IN EACH ROW**

	<b>Strongly Disagree</b>	<b>Disagree Somewhat</b>	<b>Neither Agree nor Disagree</b>	<b>Agree Somewhat</b>	<b>Strongly Agree</b>
<b>a. Physicians have a responsibility to promote the following with their patients:</b>					
eat a healthy diet.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
be adequately physically active.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
maintain a healthy weight or lose weight.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>b. Patients are more likely to adopt healthier lifestyles if physicians counsel them to do so.</b>					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>c. There are effective strategies and/or tools to help patients:</b>					
eat a healthy diet.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
be adequately physically active.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
maintain a healthy weight or lose weight.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>d. I am confident in my ability to counsel my patients:</b>					
eat a healthy diet.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
be adequately physically active.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
maintain a healthy weight or lose weight.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>e. I am effective at helping my patients</b>					
eat a healthy diet.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
be adequately physically active.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
maintain a healthy weight or lose weight.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>f. In order to effectively encourage patient adherence to a healthy lifestyle, a physician must adhere to one him/herself.</b>					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>g. Specifically, a physician will be able to provide more credible and effective counseling if he/she:</b>					
eats a healthy diet.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
is adequately physically active.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
maintains a healthy weight or loses weight.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



**B4. According to current guidelines, at what BMI level are adult patients (18 years or older) considered to be...**

**CHECK ONE IN EACH ROW**

$\geq 20 \text{ kg/m}^2$      $\geq 25 \text{ kg/m}^2$      $\geq 30 \text{ kg/m}^2$      $\geq 35 \text{ kg/m}^2$     Don't Know

a. Overweight?                   

b. Obese?                   

**B5. According to current guidelines, in what BMI percentile range are children or adolescents (2-17 years) considered to have healthy weight? CHECK ONE**

5<sup>th</sup> - 65<sup>th</sup> percentile

5<sup>th</sup> - 75<sup>th</sup> percentile

5<sup>th</sup> - 85<sup>th</sup> percentile

5<sup>th</sup> - 95<sup>th</sup> percentile

Other, specify \_\_\_\_\_

DON'T KNOW

**B6. According to current guidelines, for adults, 18 and older, how much moderate physical activity is recommended (on most days of the week) for general health and prevention of chronic diseases? CHECK ONE**

20 minutes

30 minutes

40 minutes

60 minutes

90 minutes

Other, specify \_\_\_\_\_

DON'T KNOW

**B7. According to current guidelines, for adults, 18 and older, how many servings of fruits and vegetables should a person have in a day? CHECK ONE**

3 servings

5 servings

7 servings

It depends on daily calorie intake

Other, specify \_\_\_\_\_

DON'T KNOW

**SECTION C: YOUR PERSONAL HEALTH STATUS / HEALTH BEHAVIORS**

**C1. In general, would you say your health is:** **CHECK ONE**

Excellent	Very Good	Good	Fair	Poor
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**C2. These questions are about the foods you ate or drank during the PAST MONTH, that is, the past 30 days. Please include meals and snacks eaten at home, at work or school, in restaurants, and any place else.**

	<b>CHECK ONE IN EACH ROW</b>									
	Never	1-3 times last month	1-2 times per week	3-4 times per week	5-6 times per week	1 time per day	2 times per day	3 or more times per day	4 or more times per day	5 or more times per day
a. How often did you drink 100% FRUIT Juice, such as orange, mango, apple, or grape juices? Do NOT include fruit drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
b. How often did you eat FRUIT? INCLUDE fresh, frozen or canned fruit. Do NOT include juices.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. How often did you eat FRENCH FRIES, or home fries, or hash brown potatoes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
d. How often did you eat other POTATOES? INCLUDE baked, boiled, mashed or potato salad.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
e. Not including potatoes (and not counting rice), how often did you eat OTHER VEGETABLES?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Physical Activity**

**C3. Moderate physical activities make you breathe somewhat harder than normal. During the last 7 days, did you do any moderate physical activities for at least 10 minutes? Think about activities such as bicycling, swimming, brisk walking, dancing or gardening.**

NO → GO TO C4

YES



a. On how many of the past 7 days did you do moderate physical activities?

|\_\_| DAYS

b. In the past 7 days, on a typical day in which you did moderate physical activities, how much time did you spend doing them?<sup>\*</sup>

|\_\_|\_\_|\_\_| MINUTES PER DAY

**C4. Vigorous activities make you breathe much harder than normal. Now think about vigorous activities you did that take hard physical effort, such as aerobics, running, soccer, fast bicycling, or fast swimming. During the last 7 days, did you do any vigorous physical activities in your free time for at least 10 minutes?**

NO → GO TO C5

YES



a. On how many of the past 7 days did you do vigorous physical activities?

|\_\_| DAYS

b. In the past 7 days, on a typical day in which you did vigorous physical activities, how much time did you spend doing them?

|\_\_||\_\_||\_\_| MINUTES PER DAY

**C5. Now think about activities specifically designed to STRENGTHEN your muscles, such as lifting weights or other strength-building exercises. Include all such activities even if you have included them before. During the last 7 days, did you do activities to strengthen your muscles?**

NO → GO TO C6

YES

**Height and Weight Status**

**C6. How tall are you without shoes?**

|\_| FEET      |\_|\_| INCHES

**IF YOU ARE FEMALE AND CURRENTLY PREGNANT, GO TO C7a.  
OTHERWISE GO TO C7.**

**C7. How much do you weigh without shoes?**

|\_|\_|\_| POUNDS

**C7a. If you are currently pregnant, how much did you weigh before your pregnancy?**

|\_|\_|\_| POUNDS

**C8. Are you currently trying to: CHECK ONE**

Lose weight

Gain weight

Maintain weight

I am not trying to do anything about my weight

## PHYSICIAN CHARACTERISTICS

**C9. When were you born?**

| 1 | 9 | \_ | \_ | YEAR

**C10. Are you... CHECK ONE**

Female

Male

**C11. Do you consider yourself to be Hispanic or Latino/a? CHECK ONE**

YES

NO

**C12. What do you consider to be your race? CHECK ONE OR MORE**

American Indian or Alaska Native

Asian

Black or African American

Native Hawaiian or Other Pacific Islander

White

**C13. During a typical month, approximately what percent of your professional time do you spend in the following activities?**

Percent of professional time

a. Providing Primary Care \_\_\_\_\_ %

b. Providing Subspecialty Care \_\_\_\_\_ %  
Please specify: \_\_\_\_\_

c. Research \_\_\_\_\_ %

d. Teaching \_\_\_\_\_ %

e. Administration \_\_\_\_\_ %

f. Other (*specify*): \_\_\_\_\_ %

**TOTAL**

**100 %**

## **PRACTICE CHARACTERISTICS**

**C14. Which of the following categories best describes your main primary care practice location? Are you a...**

**CHECK ALL THAT APPLY**

- |  |                          |
|--|--------------------------|
| a. Full- or part-owner of a physician practice   | <input type="checkbox"/> |
| b. Employee of a physician-owned practice  | <input type="checkbox"/> |
| c. Employee of a large medical group or health care system   | <input type="checkbox"/> |
| d. Employee of a staff or group model HMO  | <input type="checkbox"/> |
| e. Employee of a university hospital or clinic   | <input type="checkbox"/> |
| f. Employee of a hospital or clinic not associated with a university<br>(including community health clinics) | <input type="checkbox"/> |
| g. Other (specify): _____  | <input type="checkbox"/> |

**C15. Please estimate the number of patient visits that you have in a TYPICAL WEEK, EXCLUDING patient visits while on-call (on-call is defined as time outside of regularly scheduled clinical activity):**

|\_|\_|\_|\_| Number of Patient Visits

DON'T KNOW

**C16. Approximately what percentage of the patients you treat is female?**

|\_|\_|\_|\_| %

DON'T KNOW

**C17. Approximately what percentage of the patients you treat is Hispanic or Latino?....(PLEASE GIVE YOUR BEST ESTIMATE)**

**CHECK ONE**

- |               |                          |
|---------------|--------------------------|
| a. 0-5%       | <input type="checkbox"/> |
| b. 6-25%      | <input type="checkbox"/> |
| c. 26-50%     | <input type="checkbox"/> |
| d. 51-75%     | <input type="checkbox"/> |
| e. 76-100%    | <input type="checkbox"/> |
| f. DON'T KNOW | <input type="checkbox"/> |

**C18. Approximately what percentage of the patients you treat is...(PLEASE GIVE YOUR BEST ESTIMATE)**

	PERCENTAGE OF PATIENTS
a. White	___ ___ ___ %
b. Black or African-American	___ ___ ___ %
c. Asian	___ ___ ___ %
d. Native Hawaiian or Other Pacific Islander	___ ___ ___ %
e. American Indian or Alaska Native	___ ___ ___ %
<b>TOTAL</b>	<b>1 0 0 %</b>

**C19. Within a practice, there may be multiple clinical sites at which medical care is delivered.**

CHECK ONE

Does this practice have more than one clinical site?       YES       NO

**C20. About how many physicians, nurse practitioners, and physician assistants provide care in all of the clinical sites within this practice? CHECK ONE**

1

2 – 5

6 – 20

More than 20 and fewer than 100

More than 100

DON'T KNOW

**C21. If this survey were available on the Internet as a web-based questionnaire, would you prefer to fill it out online, or is a paper and pencil survey more convenient for you?**

CHECK ONE

I prefer paper and pencil

I prefer a web-based questionnaire

I have no preference

Other (please specify): \_\_\_\_\_



**C22.** We would like to obtain additional information about aspects of the practice that support disease prevention activities. However, we know your time is limited, so we'd like to send your office administrator a short questionnaire of about 20 questions related to the structure of your practice and the roles of different staff that work there. Please give us the name of your office administrator, or indicate whether it would be better for us to send the brief questionnaire to you.

Check one:  Dr.           Mr.           Ms.           Mrs.

First Name: |\_|\_|\_|\_|\_|\_|\_|\_|\_|

Last Name: |\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|

The office administrator in my practice is less familiar with the clinical roles of my staff; I am the best person to answer questions about my practice.

**If you have any comments about the questionnaire, individual questions, or the burden, please make them here. We appreciate your participation and feedback.**

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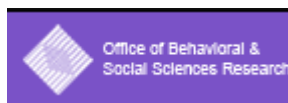
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# Physician Survey of Practices on Diet, Physical Activity and Weight Control *ADMINISTRATOR QUESTIONNAIRE*

Conducted by:



National Institute of Child Health  
and Human Development (NICHD)



Department of Health and Human Services  
Centers for Disease Control and Prevention

Public reporting burden for this response is estimated to be an average of xx minutes per questionnaire including time for reviewing instructions. Send comments regarding this burden statement or any other aspect of this collection of information including suggestions for reducing this burden to XXXXXXXXX. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0925-xxxx.

## INTRODUCTION AND INSTRUCTIONS

The Physician Survey of Practices on Diet, Physical Activity, and Weight Control is sponsored by the National Cancer Institute in collaboration with The Office of Behavioral and Social Science Research, National Institute of Child Health and Human Development, the National Institute of Diabetes and Digestive and Kidney Diseases and the Centers for Disease Control and Prevention. Obesity, poor diet, and lack of physical activity are recognized as major public health problems in the United States. The Administrator Questionnaire asks about factors that could facilitate or hinder physician's practices intended to address these problems.

The survey is being sent to a random sample of Family Medicine Physicians, General Internists, Obstetrician/Gynecologists, and Pediatricians, and their associated administrators. The following doctor in your office has participated in the physician portion of the survey:

Please provide answers to the survey questions based on the patient characteristics, clinical guidelines, and financial arrangements related to the clinical site listed above, which should be the location at which the doctor practices medicine. You may need to obtain information from multiple members of the clinic team.

The information you provide in this survey will remain confidential to the fullest extent of the law. Your answers will be combined with those of other respondents in reports to NCI and anyone else.

Participation is voluntary, and there are no penalties to you for not responding. However, not responding could seriously affect the accuracy of final results, and your point of view may not be adequately represented in the survey findings.

- Use an X in the boxes to indicate your answers.
- Use the line provided in “Other (Specify): \_\_\_\_\_” if your answer is not adequately represented by available choices.
- If you are not sure of an answer give your best estimate.

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Administrator Questionnaire

**Section A. Practice Characteristics**

**A1. Is this doctor's office part of a...**

**CHECK ONE BOX**

- Solo practice → GO TO A5
- Group practice
- Medical School
- Hospital
- Clinic or Community Health Center
- Other (Specify) \_\_\_\_\_

**A2. Is this doctor's office a...**

**CHECK ONE BOX**

- Single specialty practice
- Multi-specialty practice, where physicians from more than one specialty provide services
- Other (Specify) \_\_\_\_\_

**A3. Who owns this doctor's office?**

**CHECK ONE BOX**

- One or more physicians or a physician owned corporation
- A health system or integrated delivery system
- A health plan or insurance company
- Federal, state or local government
- A medical school, hospital, or related organization
- Other (Specify) \_\_\_\_\_

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**A4. About how many part time and full time physicians, nurse practitioners, and physician assistants work in this office?**

CHECK ONE BOX

|\_|\_|\_|\_| Number of part time and full time physicians, nurse practitioners and physician assistants

|\_|\_|\_|\_| Number of physician, nurse practitioner and physician's assistant full time equivalents (FTEs)

**A5. Which of the following types of healthcare professionals work in this office?**

PLACE AN "X" FOR ALL THAT APPLY

a. Nurse Practitioners or Clinical Nurse Specialist

b. Physician Assistants

c. Nurses (e.g., RN, LPN, LVN)

d. Dietitians/Nutritionists

e. Health Educator

f. Occupational/Physical therapists

g. Social workers

h. Psychologists

i. Medical Assistants

k. Other (Specify) \_\_\_\_\_

**A6. Where is this office located?**

CHECK ONE BOX

Large City (Population over 500,000)

Medium City (Population 100,000-500,000)

Small City (Population under 100,000)

Rural Community

Other (Specify) \_\_\_\_\_

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**A7. At this office, approximately how many patient visits with physicians, nurse practitioners, or physician assistants occur during a typical week?**

PLEASE GIVE YOUR BEST ESTIMATE

|\_|\_|\_|\_| Number of patient visits per week

**A8. In this office, approximately what percentage of the patients is...**

PLEASE GIVE YOUR BEST ESTIMATE

	0-5%	6-25%	26-50%	51-75%	76-100%	Don't Know
a. Uninsured	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Privately Insured	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Medicare Insured	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Medicaid Insured	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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**Section B. Clinical Policies and Procedures**

**B1. In this office, who usually performs the following for patients?**

PLACE AN "X" FOR ALL THAT APPLY IN EACH ROW AND EACH COLUMN

	Measuring weight and height	Assessing diet and physical activity	Counseling about, diet, physical activity, and weight control
a. Physician	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Nurse practitioner or physician assistant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Other staff (Specify): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. No one does this	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Don't know	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**B2. In this office, is there a standard protocol that requires that each patient have the following assessed?**

PLACE AN "X" IN EACH COLUMN AND EACH ROW

	Diet		Physical Activity		Weight	
	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
a. At each visit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. At new patient visit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Annually	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Other timeframe (Specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. A standard protocol is implemented ONLY for high risk patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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**B3. Does this office provide preventive medicine/well patient visits?**

YES, this site provides preventive/well patient visits

**B3a. If yes, do these visits include counseling for diet, physical activity, and weight management?**

YES

NO

No, this office does NOT provide preventive/well patient visits

I don't know

**B4. What type of medical record system does this office use?**

**CHECK ONE BOX**

Paper charts

Partial electronic medical records (e.g., lab results available electronically, but patient history on paper)

In transition from paper to full electronic medical records

Full electronic medical records



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**B5. Which of the following mechanisms does this office have to follow up with patients who have received counseling within the practice on diet, physical activity, or weight management?**

CHECK ALL THAT APPLY

Verbal reminder from the physician or other staff during an office visit	<input type="checkbox"/>
Reminder by US Mail, telephone, or e-mail	<input type="checkbox"/>
Personalized Web page or other mechanism (Specify) _____	<input type="checkbox"/>
None of these	<input type="checkbox"/>
Don't Know	<input type="checkbox"/>

**B6. Which of the following mechanisms does this office have to follow up with patients who are referred out from your practice for counseling on diet, physical activity, or weight management?**

CHECK ALL THAT APPLY

Verbal reminder from the physician or other staff during an office visit	<input type="checkbox"/>
Reminder by US Mail, telephone, or e-mail	<input type="checkbox"/>
Personalized Web page or other mechanism (Specify) _____	<input type="checkbox"/>
None of these	<input type="checkbox"/>
Don't Know	<input type="checkbox"/>

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**Section C. Information Resources**

**C1. Please indicate which of the following information resources on diet, physical activity or weight control are available in the waiting or exam rooms.**

CHECK ALL THAT APPLY

- |  |                          |
|--|--------------------------|
| a. Brochures, pamphlets  | <input type="checkbox"/> |
| b. Video   | <input type="checkbox"/> |
| c. Flyers for related programs or services (e.g., weight loss or exercise program) | <input type="checkbox"/> |
| d. Books/ Journal articles   | <input type="checkbox"/> |
| e. Magazines   | <input type="checkbox"/> |
| f. No materials are available for diet, physical activity, or weight control       | <input type="checkbox"/> |

**C2. Does the office have a newsletter that goes out to patients?**

- Yes → GO TO C2a
- No → GO TO C3

**C2a. In the past 12 months, did any of the newsletters provide information about:**

CHECK ALL THAT APPLY

- Diet/Nutrition
- Physical Activity
- Weight Control

**C3. Does the office have a website?**

- Yes → GO TO C3a
- No → GO TO D1

**C3a. If yes, in the past 12 months, did the website provide information about:**

CHECK ALL THAT APPLY

- Diet/Nutrition
- Physical Activity
- Weight Control

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**Section D Billing and Reimbursement**

**D1. Do you review or work with billing data on a regular basis?**

- Yes → GO TO D2
- No. → GO TO SECTION E, PAGE 10.

**D2. About what percentage of the office’s revenue is derived from the following sources?**

Don’t know

	PERCENTAGE OF REVENUE
<b>FILL IN PERCENTAGE FOR EACH ROW. TOTAL MUST EQUAL 100%</b>	
a. Fee-for-Service	___ ___ %
b. Capitation	___ ___ %
c. Other (Specify) _____	___ ___ %
<b>TOTAL</b>	<b>100%</b>

**D3. In this office, what types of coverage do your insured patients have? (If no patients have insurance, please indicate N/A)**

Don’t know

	<b>PLACE AN “X” IN <u>ONE</u> BOX IN <u>EACH</u> ROW</b>					
	0-5%	6-25%	26-50%	51-75%	76-100%	N/A
a. Managed Care (HMO/POS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Managed Care (PPO)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Other (specify): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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**D4. Does this office bill for visits that involve counseling for diet, physical activity, and weight control? (Under some systems, services are provided under capitation and are not billed).**

- Yes, billed as treatment for a chronic or acute condition
- Yes, billed as part of preventive medicine/well patient visit
- No, not billed
- Don't know

**D5. Do physicians working in this office receive any incentive payments to engage in the following?**

PLACE AN "X" IN ONE BOX IN EACH ROW

	Yes	No	Don't Know
a. Diabetes screening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Cancer screening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Heart disease screening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Diet counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Physical activity counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Weight counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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**Section E Personal Characteristics**

**E1. What is your position or title?**

\_\_\_\_\_

**E2. How long have you been with the practice?**

| \_\_\_\_ | \_\_\_\_ | Month or Years (Circle One)

**E3. If this survey were available on the Internet as a web-based questionnaire, would you prefer to fill it out online, or is a paper and pencil survey more convenient for you?**

**CHECK ONE**

I prefer paper and pencil

I prefer a web-based questionnaire

I have no preference

Other (please specify): \_\_\_\_\_

Please add any comments in the space provided. We appreciate your participation and feedback.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

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