OMB#: 0925-0587 EXP. DATE: 4/30/2011

DIET AND HEALTH STUDY

NATIONAL INSTITUTES OF HEALTH AND AARP

NIH–AARP Diet and Health Study
Short Questionnaire

Survey ID #: * 0 0 0 0 0 0 0 5 *

STATEMENT OF CONFIDENTIALITY

Collection of this information is authorized by The Public Health Service Act, Section 412 (42 USC 285 a-1). Rights of study participants are protected by The Privacy Act of 1974. Participation is voluntary, and there are no penalties for not participating or withdrawing from the study at any time. Refusal to participate will not affect your benefits in any way. The information collected in this study will be held in professional confidence. Names and other identifiers will be separated from information provided and will not appear in any report of the study. Information provided will be combined for all study participants and report as statistical summaries.

NOTIFICATION TO RESPONDENT OF ESTIMATED BURDEN

Public reporting burden for this collection of information is estimated to average 4 minutes per response, including the time for review instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. **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**. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-0587). Do not return the completed form to this address.

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.)*

EXAMPLE 1: If you weigh 186 pounds, your entry would be:

POUNDS

1	8	6
0	0	0
●	1	1
2	2	2
3	3	3
4	4	4
5	5	5
	6	●
	7	7
	●	8
	9	9

EXAMPLE 2: If you weigh 94 pounds, your entry would be:

POUNDS

0	9	4
●	0	0
1	1	1
2	2	2
3	3	3
4	4	●
5	5	5
	6	6
	7	7
	8	8
	●	9

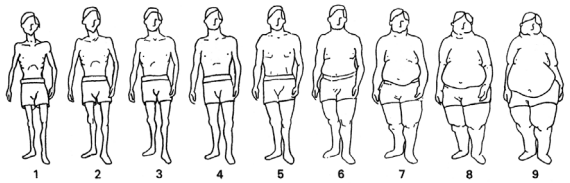
Your Current Weight

POUNDS

0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
	6	6
	7	7
	8	8
	9	9

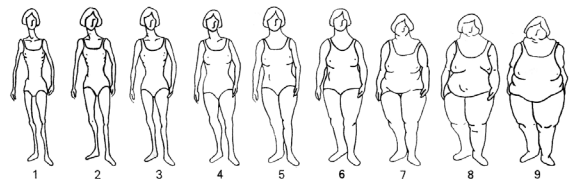
2. For each of the ages shown below, select the diagram that best describes your body shape at that age. *(Mark one circle at each age.)*

Men



	1	2	3	4	5	6	7	8	9
Age 10	○	○	○	○	○	○	○	○	○
Age 18	○	○	○	○	○	○	○	○	○
Age 35	○	○	○	○	○	○	○	○	○
Age 50	○	○	○	○	○	○	○	○	○
Currently	○	○	○	○	○	○	○	○	○

Women



	1	2	3	4	5	6	7	8	9
Age 10	○	○	○	○	○	○	○	○	○
Age 18	○	○	○	○	○	○	○	○	○
Age 35	○	○	○	○	○	○	○	○	○
Age 50	○	○	○	○	○	○	○	○	○
Currently	○	○	○	○	○	○	○	○	○

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	2004–2006	2007–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	2004–2006	2007–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 ○ 2004–2006 ○ 2007–present

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

○ No ○ Yes ☞ Date of most recent surgery: ○ Before 2004 ○ 2004–2006 ○ 2007–present
☞ How many ovaries do you have remaining? ○ None ○ One

THANK YOU!

Please return the completed questionnaire in the pre-paid envelope provided.