Attachment 3

Clinic Eligibility Screening Interview **OMB#: 0925-#### EXP.DATE: ##/##/2011**

NOTIFICATION TO RESPONDENT OF ESTIMATED BURDEN

Public reporting burden for this collection of information is estimated to average 10 minutes for this questionnaire, including the time to review instructions, search existing data sources, gather and maintain the data needed, and complete and review 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 current, 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 (####-####).

CLINIC VISIT #1: INTRODUCTORY QUESTIONNAIRE

Instructions: The following form will be provided to participants upon arriving to the first clinic visit. Contact information will be pre-populated based on information collected during the telephone screening interview.

OMB #: 0925-xxxx
Expiry Date: xx/xx/2011

ID LABEL

ENROLLMENT FORM AND ELIGIBILITY SCREENER

Date: [Pre-populated Month/Day/Year]

1. Personal Contact Information

[Pre-populated with known information when possible]

FIRST NAME | MIDDLE INITIAL | LAST NAME | SUFFIX

STREET ADDRESS | CITY | STATE | ZIP CODE

HOME PHONE # | WORK PHONE # | MOBILE PHONE #

BEST TIME TO CALL

EMAIL ADDRESS

Please provide the following information.

2. DATE OF BIRTH: _____/_____/_____
MONTH DAY YEAR

3. GENDER: ☐ MALE
☐☐FEMALE

4. ETHNICITY: ☐☐HISPANIC OR LATINO
☐☐NOT HISPANIC OR LATINO

5. RACE: ☐☐AMERICAN INDIAN OR ALSKA NATIVE
☐☐ASIAN
☐☐BLACK OR AFRICAN AMERICAN
☐☐NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
☐☐WHITE

Please answer the following questions about your internet access.

6. DO YOU HAVE ACCESS TO A COMPUTER AND HIGH-SPEED INTERNET? ☐ YES ☐ NO

7. ARE YOU ABLE TO ANSWER ONLINE SURVEYS THAT MAY TAKE UP TO AN HOUR TO COMPLETE? ☐ YES ☐ NO

Please answer the following questions about your health.

8. ARE YOU CURRENTLY TRYING TO LOSE WEIGHT? ☐ YES ☐ NO

9. ARE YOU CURRENTLY USING SUPPLEMENTAL OXYGEN? ☐ YES ☐ NO

10. ARE YOU CURRENTLY TAKING BETA-BLOCKERS FOR A HEART CONDITION? ☐ YES ☐ NO

11. HAS A HEALTH PROFESSIONAL EVER TOLD YOU THAT YOU HAVE…

a. HIGH BLOOD SUGAR THAT REQUIRES DAILY INSULIN SHOTS TO CONTROL? ☐ YES ☐ NO

b. CONGESTIVE HEART FAILURE? ☐ YES ☐ NO

c. KIDNEY FAILURE THAT REQUIRES DIALYSIS? ☐ YES ☐ NO

d. DIFFICULTY WITH FLUID RETENTION (SWELLING OF MORE THAN 5 POUNDS)? ☐ YES ☐ NO

e. MALABSORPTION, FOOD ABSORPTION PROBLEMS, CHROHN'S DISEASE? ☐ YES ☐ NO

f. HEMOPHILIA? ☐ YES ☐ NO

12. DO YOU HAVE A SENSITIVITY TO THE NUTRITIONAL SUPPLEMENT CALLED PABA OR HAVE YOU EVER DEVELOPED A RASH OR ITCHING AFTER APPLYING SUNSCREEN? ☐ YES ☐ NO

13. ARE YOU ABLE TO STOP TAKING MEDICATIONS CONTAINING ACETAMINOPHEN, SULPHONIMIDES, OR VITAMIN SUPPLEMENTS FOR THE 2 DAY URINE COLLECTION? ☐ YES ☐ NO

14. BY YOURSELF AND WITHOUT USING ANY SPECIAL EQUIPMENT, DO YOU THINK YOU COULD WALK FOR A QUARTER OF A MILE (ABOUT 2 OR 3 BLOCKS)? ☐ YES ☐ NO

15. Please provide the names of two contacts who could be reached in case we cannot reach you.

CONTACT PERSON #1

FIRST NAME | MIDDLE INITIAL | LAST NAME | SUFFIX

STREET ADDRESS | CITY | STATE | ZIP CODE

HOME PHONE # | WORK PHONE # | MOBILE PHONE #

RELATIONSHIP TO YOU

CONTACT PERSON #2

FIRST NAME | MIDDLE INITIAL | LAST NAME | SUFFIX

STREET ADDRESS | CITY | STATE | ZIP CODE

HOME PHONE # | WORK PHONE # | MOBILE PHONE #

RELATIONSHIP TO YOU

DETERMINATION OF ELIGIBILITY

☐☐Signed informed consent form

AND

☐☐All questions 6-14 are answered 'Yes'

ELIGIBLE

☐☐Did not sign informed consent form

OR

☐☐Any question 6-14 is answered 'No'

NOT ELIGIBLE

- END OF QUESTIONNAIRE -