

Form Approved
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YOUTH BIOMETRIC MEASURES

(Ages 12-17)

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YOUTH BIOMETRIC MEASURES (Ages 12-17)

Interviewer _____

Study ID # | | | | |

Date of Completion _____

Time of Completion _____

Now I'm going to begin with some general questions about your health that relate to the biometric measures we will be collecting today

PART A.

EIGHT

How do **you** describe your weight? Would you say....

- . Very underweight
- . Slightly underweight
- . About the right weight
- . Slightly overweight
- . Very overweight
- . DON'T KNOW
- . REFUSED

Which of the following are you trying to do about your weight?

- . **Lose** weight
- . **Gain** weight
- . **Stay** the same weight
- . I am **not trying to do anything** about my weight
- . DON'T KNOW
- . REFUSED

During the past 30 days, did you **go without eating for 24 hours or more** (also called fasting) to lose weight or to keep from gaining weight?

- . Yes
- . No
- . DON'T KNOW
- . REFUSED

During the past 30 days, did you **take any diet pills, powders, or liquids** without a doctor's advice to lose weight or to keep from gaining weight? (Do **not** include meal replacement products such as Slim Fast.)

- . Yes
- . No
- . DON'T KNOW
- . REFUSED

During the past 30 days, did you **vomit or take laxatives** to lose weight or to keep from gaining weight?

- . Yes
- . No
- . DON'T KNOW
- . REFUSED

During the past 30 days, have you gained weight?

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Yes – How many pounds? _____ lbs

No

Don't know

Refused

During the past 30 days, have you lost weight?

Yes – How many pounds? _____ lbs

No

Don't know

Refused

TOBACCO SMOKE/EXPOSURE

Now I'm going to ask you questions about smoking. I will ask the question and you can tell me the number on the card that shows what your answer is. I will be asking these questions of everybody whether or not they say they smoke.

During the past 7 days, on how many days were you in the same room with somebody who was smoking cigarettes?

ENTER NUMBER OF DAYS: _____

DON'T KNOW

REFUSED

Do you currently smoke cigarettes, cigarillos, cigars or pipe?

1 Yes

2 No - SKIP TO QUESTION 10

DON'T KNOW - SKIP TO QUESTION 10

REFUSED - SKIP TO QUESTION 10

9a How much do you usually smoke per day?

_____ Cigarettes

_____ Cigarillos

_____ Cigars

_____ Pipes

DON'T KNOW

REFUSED

YOUTH BIOMETRIC MEASURES (Ages 12-17)

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10. How long has it been since you last smoked a cigarette, cigarillo, cigar or pipe, even one or two puffs?

_____ Hours ago

_____ Days ago

_____ Months ago

_____ Never smoked

DON'T KNOW

REFUSED

11. Do you currently use chewing tobacco, snuff, or dip such as Redman, Skoal, or Copenhagen?

1 Yes

2 No – SKIP TO QUESTION 12

DON'T KNOW – SKIP TO QUESTION 12

REFUSED – SKIP TO QUESTION 12

(

11a. Approximately how long ago did you last use any of those?

_____ Hours ago

_____ Days ago

_____ Months ago

_____ Never used

DON'T KNOW

REFUSED

12. Are currently using anything to help you quit smoking like a nicotine patch, nicotine gum, nasal spray or inhaler?

Yes

No – SKIP TO QUESTION 13

DON'T KNOW – SKIP TO QUESTION 13

REFUSED – SKIP TO QUESTION 13

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12a. When did you last use any of these things that are designed to help you quit smoking?

_____ Currently using (e.g. patch)

Hours ago

Days ago

_____ Months ago

_____ Never used

RECENT FOOD INTAKE

13. What food or foods did <you> eat during your last meal or snack? Please list all the food and drinks you have had during your last meal or snack.

13a. what time was that food eaten? _____ AM/PM _____

14. Are you currently fasting?

1 Yes

2 No

7 Don't know / Not sure

9 Refused

RECENT ILLNESS

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15. List any cold, flu or other illness you have had in the last 2 weeks. For each one, please tell me how recently the illness occurred.

If no illness in last 2 weeks, check here: _____

Illness	Today	Last 2 days	Last 2 weeks
1) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The next few questions will help us understand the results of your saliva sample.

16. Has a doctor or dentist told you that you had periodontal disease (that is, an infection of the soft tissues and bones surrounding the teeth)?

Yes

No

DON'T KNOW

REFUSED

17. Do you have braces?

Yes

No

DON'T KNOW

REFUSED

18. Before this visit, when was the last time you brushed your teeth?

Time: _____ AM/PM
 18a The last time you brushed your teeth, did you see any pink or reddish color when you spit into the sink?

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- Yes
- No
- DON'T KNOW
- REFUSED

19. In the past 24 hours have you had any injuries to your mouth or any dental work that caused bleeding?

- Yes
- No
- DON'T KNOW
- REFUSED

20. Do you have any open sores or cuts in your mouth?

- Yes
- No
- DON'T KNOW
- REFUSED

RECENT MEDICATION USE

21. What medications are you currently taking? (Prescription medications, OTC, vitamins, dietary supplements etc.)

INTERVIEWER INSTRUCTION – IF THE PERSON IS CURRENTLY TAKING THE MEDICATION, INDICATE “ONGOING” FOR THE STOP DATE AND MARK “ONGOING” AS YES.

_____ No medication

NAME (brand/generic)	DOSE (Mg etc.)	FREQUENCY (1X, 2X etc.)	ROUTE (Oral, shot etc.)	INDICATION (Hypertension etc.)	START DATE (MM/YR)	STOP DATE (MM/YR)	ONGOING? (Yes/No)
<i>Example: Norvasc/Amlodipine</i>	<i>5mg</i>	<i>1X</i>	<i>oral</i>	<i>High Blood Pressure</i>	<i>3/2008</i>	<i>ongoing</i>	

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PART B.

CHILD HEIGHT	MEASURED CM.....	_
	RF.....	9999
CHILD WAIST CIRCUMFERENCE	MEASURED CM.....	_
	RF.....	9999
CHILD WEIGHT	MEASURED KG.....	_
	RF.....	9999

SALIVA SAMPLE COLLECTED YES/NO.....

a. SALIVA SAMPLE # ID..... |_|

b. SALIVA SAMPLE SHIPPING # ID..... |_|

6. CHILD ACCELEROMETRY STUDY PARTICIPANT? YES/NO.....

c. ACCELEROMETER ID # ID..... |_|