MULTIPLE RISK FACTOR INTERVENTION TRIAL F040 F694

FIRST ANNUAL MEDICAL HISTORY AND BEHAVIOR QUESTIONNAIRE

Year of Follow-up [1]

Attach ID Label Here

The following set of questions includes a Medical History Questionnaire and some questions to study the relationship between the occurrence of heart disease and factors such as behavioral characteristics and physical activity. These questions are arranged in five parts. They are as follows:

Part I – Medical History
Part II – Events During the Past Year
Part III – Interests and Feelings
Part IV – Leisure Time Physical Activities
Part V – Nutrition

Please follow these directions when completing this questionnaire:

1. Read every question carefully and answer every one. Unless otherwise indicated, only one response should be selected for each question. PLEASE USE BALLPOINT PEN AND PRESS FIRMLY.
2. It is essential that you bring this completed questionnaire with you to your scheduled appointment. A protective envelope is enclosed for your convenience. PLEASE DO NOT FOLD THE QUESTIONNAIRE.

   The answers you give are treated completely confidentially and will become part of your study record.

PLEASE BRING ALL MEDICINES THAT YOU ARE CURRENTLY TAKING, OR HAVE TAKEN DURING THE PAST TWO WEEKS, TO THE NEXT VISIT SO THAT THE DOCTOR CAN IDENTIFY THEM.

Your present address and telephone number:

CC USE 1☐

ADDRESS: _____
Street Apartment No.

_____
City State Zip Code

Telephone Number _____

If you wish the results of the tests, the ECG and physical examination sent to your physician, please give his name and address below and check the box. ☐

CC USE 1☐

NAME _____

ADDRESS _____
Street Apartment No.

City State Zip Code

Please give the name and address of someone who is not living in your household but who will know where you are if we should need to contact you. If this person is a married woman, please give her husband's name also in the space provided

CC USE 1☐

Name First Last Husband

Street No. and Name

City State Zip Code

Telephone Number

PART I – MEDICAL HISTORY QUESTIONNAIRE

A complete and accurate medical history is essential in evaluating your health status. This questionnaire is intended to help you become more aware of your physical well-being and to help our staff with your examination at the next visit.

DURING THE PAST 12 MONTHS HAS A DOCTOR TOLD YOU THAT YOU HAD ANY OF THE FOLLOWING?
(Check either yes, no, or not sure for each item.)

MHQ01V12	1. High blood pressure (hypertension)	1 ☐ yes	2 ☐ no	3 ☐ not sure
MHQ02V12	2. Heart attack (myocardial infarction, coronary occlusion or coronary thrombosis)	1 ☐ yes	2 ☐ no	3 ☐ not sure
MHQ03V12	3. Angina	1 ☐ yes	2 ☐ no	3 ☐ not sure
MHQ04V12	4. Congenital heart disease (born with heart defect)	1 ☐ yes	2 ☐ no	3 ☐ not sure
MHQ05V12	5. Rheumatic fever, chorea (St. Vitus Dance)	1 ☐ yes	2 ☐ no	3 ☐ not sure
MHQ06V12	6. Rheumatic heart disease	1 ☐ yes	2 ☐ no	3 ☐ not sure
MHQ07V12	7. Stroke	1 ☐ yes	2 ☐ no	3 ☐ not sure
MHQ08V12	8. Diabetes (sugar in the blood or urine)	1 ☐ yes	2 ☐ no	3 ☐ not sure
MHQ09V12	9. Gout	1 ☐ yes	2 ☐ no	3 ☐ not sure
MHQ10V12	10. Kidney disease (nephritis, pyelonephritis, glomerulonephritis, kidney infection)	1 ☐ yes	2 ☐ no	3 ☐ not sure
MHQ11V12	11. Kidney stones	1 ☐ yes	2 ☐ no	3 ☐ not sure
MHQ12V12	12. Prostate infection, enlargement or other prostate disease	1 ☐ yes	2 ☐ no	3 ☐ not sure
MHQ13V12	13. Urinary tract infection, bladder infection, other bladder disease	1 ☐ yes	2 ☐ no	3 ☐ not sure
MHQ14V12	14. Bronchitis	1 ☐ yes	2 ☐ no	3 ☐ not sure
MHQ15V12	15. Pneumonia	1 ☐ yes	2 ☐ no	3 ☐ not sure
MHQ16V12	16. Pleurisy	1 ☐ yes	2 ☐ no	3 ☐ not sure
MHQ17V12	17. Emphysema	1 ☐ yes	2 ☐ no	3 ☐ not sure
MHQ18V12	18. Tuberculosis	1 ☐ yes	2 ☐ no	3 ☐ not sure
MHQ19V12	19. Thyroid problem or disease	1 ☐ yes	2 ☐ no	3 ☐ not sure
MHQ20V12	20. Colitis or inflammation of the colon	1 ☐ yes	2 ☐ no	3 ☐ not sure
MHQ21V12	21. Ulcer (stomach or duodenal), or intestinal bleeding	1 ☐ yes	2 ☐ no	3 ☐ not sure
MHQ22V12	22. Hepatitis	1 ☐ yes	2 ☐ no	3 ☐ not sure
MHQ23V12	23. Cirrhosis or other liver disease	1 ☐ yes	2 ☐ no	3 ☐ not sure
MHQ24V12	24. Anemia	1 ☐ yes	2 ☐ no	3 ☐ not sure
MHQ25V12	25. Cancer	1 ☐ yes	2 ☐ no	3 ☐ not sure
MHQ26V12	26. Nervous, emotional or mental disorder	1 ☐ yes	2 ☐ no	3 ☐ not sure
MHQ27V12	27. Rheumatoid arthritis	1 ☐ yes	2 ☐ no	3 ☐ not sure
MHQ28V12	28. Other arthritis	1 ☐ yes	2 ☐ no	3 ☐ not sure
	29. Epilepsy or seizures or fits	1 ☐ yes	2 ☐ no	3 ☐ not sure
MHQ30V12	30. Allergies	1 ☐ yes	2 ☐ no	3 ☐ not sure
MHQ31V12	31. Asthma	1 ☐ yes	2 ☐ no	3 ☐ not sure
MHQ32V12	32. Hives or hay fever	1 ☐ yes	2 ☐ no	3 ☐ not sure
	33. Other major diseases (specify) _____	1 ☐ yes	2 ☐ no	3 ☐ not sure

34. During the past 12 months have you been told by a doctor that you have gallstones or gall bladder disease?	1 ☐ yes	2 ☐ no	3 ☐ not sure
35. During the past 12 months have you had x-rays taken of your gall bladder?	1 ☐ yes	2 ☐ no	3 ☐ not sure
36. During the past 12 months have you had surgery for gall bladder disease?	1 ☐ yes	2 ☐ no	3 ☐ not sure

DURING THE PAST 12 MONTHS HAVE YOU EXPERIENCED ANY OF THE FOLLOWING?

37. Skin rash or unusual bruises?	1 ☐ yes	2 ☐ no	3 ☐ not sure
38. Headaches that were so bad you had to stop what you were doing?	1 ☐ yes	2 ☐ no	3 ☐ not sure
39. Headache attack, racing heart and sweating, all at the same time?	1 ☐ yes	2 ☐ no	3 ☐ not sure
40. Faintness or light-headedness when you stand up quickly?	1 ☐ yes	2 ☐ no	3 ☐ not sure
41. Your heart beating unusually fast or skipping beats?	1 ☐ yes	2 ☐ no	3 ☐ not sure
42. Blacking out or losing consciousness?	1 ☐ yes	2 ☐ no	3 ☐ not sure
43. Frequent stomach pains?	1 ☐ yes	2 ☐ no	3 ☐ not sure
44. Waking up early, having trouble getting back to sleep?	1 ☐ yes	2 ☐ no	3 ☐ not sure
45. Black or tarry stools?	1 ☐ yes	2 ☐ no	3 ☐ not sure
46. Bright red blood in your stools?	1 ☐ yes	2 ☐ no	3 ☐ not sure
47. Allergies to medicines?	1 ☐ yes	2 ☐ no	3 ☐ not sure
48. Unexplained weight loss?	1 ☐ yes	2 ☐ no	3 ☐ not sure

49 **Were** you hospitalized for any reason in the past 12 months?

HOSP12

1 ☐ yes → Please give the name and address of the hospital you visited.

2 ☐ no

A. _____ Hospital

_____ Street

_____ City - State

B. _____ Hospital

_____ Street

_____ City - State

C. _____ Hospital

_____ Street

_____ City - State

50. During the past 12 months, about how many times have you seen or talked to a medical doctor for health reasons? Do not count the MRFIT physicians. (check one)

77 1 ☐ zero times during past year 2 ☐ one - two times during past year 3 ☐ three - five times during past year 4 ☐ six or more times during past year

51. During the past 12 months, about how many visits have you made to the dentist? (check one)

78 1 ☐ zero times during past year 2 ☐ one time during past year 3 ☐ two times during past year 4 ☐ three or more times during past year

52. About how many days during the past 12 months were you kept in bed for all or most of the day because of illness, disability or injury?

79 1 ☐ zero - three days during past year 2 ☐ four - six days during past year 3 ☐ seven - nine days during past year 4 ☐ ten or more days during past year

ASPIR12 **53.** During the past four weeks, how often did you take aspirin or similar drugs such as Alka-Seltzer, Anacin, APC, Bufferin, Darvon, Dristan, Empirin, or Excedrin? (check one)

80 1 ☐ daily 2 ☐ four, five, six days per week 3 ☐ one, two, three days per week 4 ☐ occasionally - less often than one day per week 5 ☐ not at all

PLEASE ANSWER THE FOLLOWING QUESTIONS AS DIRECTED

CHF12

54. Do you ever wake up at night gasping for breath? 81 1 ☐ yes 2 ☐ no

55. Do you usually cough first thing in the morning in the winter? (If you cough with your first smoke or when first going outside, you should mark "yes". Do not respond "yes" for clearing of throat or a single cough.) 82 1 ☐ yes 2 ☐ no

COUGH12

56. Do you usually cough during the day or at night in the winter? (Do not respond "yes" for a single cough.)

83 1 ☐ yes → 57. Do you cough like this on most days for as much as 3 months each year? 84 1 ☐ yes 2 ☐ no

2 ☐ no

Continue with question 58.

58. Do you usually bring up any phlegm (mucus) from your chest first thing in the morning in the winter? 1 ☐ yes 2 ☐ no

PHLEGM12

59. Do you usually bring up any phlegm from your chest during the day—or at night—in the winter?

86 1 ☐ yes → 60. Do you bring up phlegm like this on most days for as much as 3 months each year? 87 1 ☐ yes 2 ☐ no

2 ☐ no

61. In the past 3 years, have you had a period of increased cough and phlegm lasting for 3 weeks or more? 88 1 ☐ yes, once 2 ☐ yes, more than once 3 ☐ no

62. Are you troubled by shortness of breath when hurrying on level ground or walking up a slight hill? 89 1 ☐ yes 2 ☐ no

DYSPNE12

63. Do you get short of breath walking with other people of your own age on level ground? 90 1 ☐ yes 2 ☐ no

64. Have you ever had asthma? 91 1 ☐ yes 2 ☐ no

65. Have you ever had any pain or discomfort in your chest?

92 1 ☒ yes → 67. Do you get it when you walk uphill or hurry? 94 1 ☐ yes 2 ☐ no

2 ☐ no 68. Do you get it when you walk at an ordinary pace on the level? 95 1 ☐ yes 2 ☐ no

ROSEAN12☐
ROSEMI12

69. When you get it in your chest what do you do?
96 1 ☒ stop 2 ☐ slow down 3 ☐ continue at same pace

66. Have you ever had any pressure or heaviness in your chest?

70. Does it go away when you stand still?

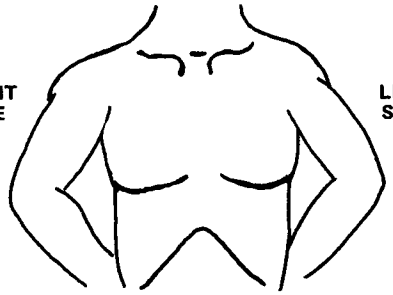
97 1 ☐ yes → 71. How soon? 98 1 ☐ 10 min. or less 2 ☐ more than 10 min.
Continue with question 72.

2 ☐ no

93 1 ☐ yes →

2 ☐ no

72. Where do you get this pain or discomfort? (Mark the place or places with an "X" on the diagram.)



DO NOT USE

99 1 ☒ yes 2 ☐ no

100 1 ☒ yes 2 ☐ no

101 1 ☐ yes 2 ☐ no

73. Have you ever had a severe pain across the front of your chest lasting for half an hour or more? 102 1 ☐ yes 2 ☐ no

74. Do you get a pain in either leg on walking?

103 1 ☐ yes → 75. Does this pain ever begin when you are standing still or sitting? 104 1 ☐ yes 2 ☐ no

2 ☐ no 76. Do you get this pain in your calf? (or calves?) 105 1 ☐ yes 2 ☐ no

ROSEIC12

77. Do you get it when you walk uphill or hurry? 106 1 ☐ yes 2 ☐ no

78. Do you get it when you walk at an ordinary pace on the level? 107 1 ☐ yes 2 ☐ no

79. Does the pain ever disappear while you are still walking? 108 1 ☐ yes 2 ☐ no

80. What do you do if you get it when you are walking?
109 1 ☐ stop 2 ☐ slow down 3 ☐ continue at same pace

Continue with question 82.

81. What happens to it if you stand still?
110 1 ☐ usually continues more than 10 min. 2 ☐ usually disappears in 10 min. or less

82. In the past 12 months, have you had any sudden feeling of numbness, tingling or loss of feeling in either arm, hand, leg, foot or face?

111 1 ☐ yes → 83. How many attacks of such numbness or tingling have you had?

112 1 ☐ only one 2 ☐ two 3 ☐ three - five 4 ☐ more than five

84. How long did the attack(s) usually last?

113 1 ☐ usually less than 5 minutes 2 ☐ from 5 minutes to an hour 3 ☐ from 1 to 6 hours
4 ☐ from 6 to 24 hours 5 ☐ more than a day

85. Did you see a doctor for the numbness or tingling? 114 1 ☐ yes 2 ☐ no

2 ☐ no

NDNUMB12

86. During the past 12 months, have you had any sudden attacks of paralysis or loss of use of either arm, hand, leg or foot?

115 1 ☐ yes → 87. How many attacks of such paralysis have you had?

116 1 ☐ only one 2 ☐ two 3 ☐ three - five 4 ☐ more than five

2 ☐ no

88. How long did the attack(s) usually last?

117 1 ☐ usually less than 5 minutes 2 ☐ from 5 minutes to an hour 3 ☐ from 1 to 6 hours
4 ☐ from 6 to 24 hours 5 ☐ more than a day

NDPARL12

89. Did you see a doctor for this paralysis? 118 1 ☐ yes 2 ☐ no

90. In the past 12 months, have you had any sudden loss of eyesight or blurring of vision for a short period of time?

119 1 ☐ yes → 91. What part of your vision was affected?

120 1 ☐ right eye 2 ☐ left eye 3 ☐ both eyes
4 ☐ vision to the right side 5 ☐ vision to the left side

2 ☐ no

92. How many attacks of loss of eyesight or blurring of vision have you had?

121 1 ☐ only one 2 ☐ two 3 ☐ three - five 4 ☐ more than five

93. How long did the attack(s) usually last?

122 1 ☐ usually less than 5 minutes 2 ☐ from 5 minutes to an hour 3 ☐ from 1 to 6 hours
4 ☐ from 6 to 24 hours 5 ☐ more than a day

NDANOP12

94. Did you see a doctor for this vision problem? 123 1 ☐ yes 2 ☐ no

95. In the past 12 months, have you had any sudden attacks of changes in speech, loss of speech or inability to say words for more than two minutes?

124 1 ☐ yes → 96. How many attacks of loss of speech have you had?

125 1 ☐ only one 2 ☐ two 3 ☐ three - five 4 ☐ more than five

2 ☐ no

97. How long did the attack(s) usually last?

126 1 ☐ usually less than 5 minutes 2 ☐ from 5 minutes to an hour 3 ☐ from 1 to 6 hours
4 ☐ from 6 to 24 hours 5 ☐ more than a day

NDDYSP12

98. Did you see a doctor for your speech problem? 127 1 ☐ yes 2 ☐ no

Continue with question 99.

99. During the past 12 months, have you had any spells of dizziness, difficulty in walking, lightheadedness or loss of balance? For each condition check whether an attack occurred or not.

	Yes	No
Dizziness	1 ☐	2 ☐
Spinning sensation (vertigo)	1 ☐	2 ☐
Loss of balance	1 ☐	2 ☐
Difficulty walking	1 ☐	2 ☐
Blackouts or fainting	1 ☐	2 ☐

100. Is "yes" checked one or more times in question 99?

1 ☐ yes →

101. About how many total attacks of all conditions checked do you think you have had in the past 12 months?

1 ☐ only one 2 ☐ two 3 ☐ three - five 4 ☐ more than five

102. How long did attack(s) usually last?

1 ☐ usually less than 5 minutes 2 ☐ from 5 minutes to an hour
3 ☐ from 1 to 6 hours 4 ☐ from 6 to 24 hours 5 ☐ more than a day

103. Did you see a doctor for any of these spells? 1 ☐ yes 2 ☐ no

Continue with Part II

2 ☐ no

NDATAX12

Continue with Part II

NDALL12

CC USE

1 ☐

SKIP 138-END

PART II – EVENTS DURING THE PAST YEAR

Read down the list of events and put a ✓ after any event which you have experienced within the past 12 months.

Events Concerning Your Health

Within the past 12 months, have you experienced:

1. A physical illness or injury which kept you in bed for a week or more, or sent you to the hospital? 1 ☐
2. Worries about physical symptoms which the doctor couldn't explain? 1 ☐
3. Mental illness or problems that required hospitalization? 1 ☐
4. The realization that you are an alcoholic or a drug addict? 1 ☐
5. A major change in eating, sleeping, or smoking habits? 1 ☐
6. A change in your physical appearance such as the development of scars, major weight change, or limp? 1 ☐
7. Not being able to do things you used to because of age? 1 ☐
8. A change in your usual level of physical activity? 1 ☐

Events Concerning You and Your Work

Within the past 12 months, have you experienced:

9. A change to a new type of work? 1 ☐
10. A demotion? 1 ☐
11. Failure of your business? 1 ☐
12. Personal troubles with your boss, fellow workers, or people working under your supervision? 1 ☐
13. Not being able to work because of disability? 1 ☐
14. Being fired or laid off work? 1 ☐
15. Quitting your job? 1 ☐
16. Problems getting a new job? 1 ☐
17. Retirement from work? 1 ☐

Events Concerning Your Feelings and Thoughts

Within the past 12 months, have you experienced:

18. Feelings of being overwhelmed by difficult life situations? 1 ☐
19. The realization that you will never attain an important goal? 1 ☐
20. More thoughts about dying than usual? 1 ☐
21. Planning a suicide? 1 ☐
22. Unpleasant thoughts or images which keep coming back? 1 ☐
23. Feeling confused for over 3 days? 1 ☐
24. Feeling very angry, nervous, or sad for over 3 days? 1 ☐
25. Feeling worried about financial security? 1 ☐
26. Feelings of intense loneliness? 1 ☐
27. Feelings of being intensely disliked by someone? 1 ☐
28. Feelings of being uninvolved, distant from others, or very shy? 1 ☐

Events Concerning Your Marriage

Within the last 12 months, have you experienced:

29. Getting married? 1 ☐
30. In-law problems? 1 ☐
31. Separation from your wife because of marital problems? 1 ☐
32. Starting to live with your wife again after having been separated? 1 ☐
33. Problems because of your wife's health? 1 ☐
34. Getting divorced? 1 ☐

Events Concerning You and Your Children

Within the last 12 months, have you experienced:

35. Serious concern over your child's health? 59 1 ☐
36. Having your child doing very poorly in school? 60 1 ☐
37. Being persistently disobeyed by your child? 61 1 ☐
38. Having your child run away or get into serious trouble? 62 1 ☐
39. Intense arguments or disagreements with an older child? 63 1 ☐
40. Loss of contact with, or separation on bad terms from your child? 64 1 ☐

Events Concerning You and Others Not of Your Family

Within the last 12 months, have you experienced:

41. Doing something that caused another person's injury? 65 1 ☐
42. A "falling-out" of a close friendship? 66 1 ☐
43. Discrimination because of your race, age, religion, or appearance? 67 1 ☐
44. Fewer social activities than before? 68 1 ☐

Other Important Events

Within the last 12 months, have you experienced:

45. A change in where you live? 69 1 ☐
46. Involvement in a law suit (other than divorce) or a court appearance on a serious charge? 70 1 ☐
47. Serious or persistent financial difficulties? 71 1 ☐
48. Giving up a hobby or sport? 72 1 ☐
49. Being the victim of a crime such as assault or burglary? 73 1 ☐
50. An accident (automobile, at work, home, etc.)? 74 1 ☐
51. A vacation? 75 1 ☐

PART III – INTERESTS AND FEELINGS

Please place a ✓ in one box for each question.

1. Taking into account the way your life is, are you satisfied with the opportunities you have to develop your interests, talents, and abilities the way you would like? 76 1 ☐ yes 2 ☐ no 3 ☐ not sure
2. Does the work you do give you a feeling of self-importance and success? 77 1 ☐ yes 2 ☐ no 3 ☐ not sure
3. Do you have any special interest, talent, or hobby that gives you a feeling of success? 78 1 ☐ yes 2 ☐ no 3 ☐ not sure
4. Do you feel sure of your social acts and manners? 79 1 ☐ yes 2 ☐ no 3 ☐ not sure
5. Do you think that your looks and appearances have tended to help you? 80 1 ☐ yes 2 ☐ no 3 ☐ not sure
6. Do you feel sure that people are interested in your ideas and what you are going to do? 81 1 ☐ yes 2 ☐ no 3 ☐ not sure
7. Do you feel satisfied in your relations with members of the opposite sex? 82 1 ☐ yes 2 ☐ no 3 ☐ not sure
8. Do you wonder whether people like and respect you? 83 1 ☐ yes 2 ☐ no 3 ☐ not sure
9. On the whole, does life tend to be happy for you? 84 1 ☐ yes 2 ☐ no 3 ☐ not sure
10. Do you feel left out of the groups you go with? 85 1 ☐ yes 2 ☐ no 3 ☐ not sure
11. Are you sure you know what you most want out of life? 86 1 ☐ yes 2 ☐ no 3 ☐ not sure
12. Does the work you do bring out your best talents and abilities, and give you a chance to try out ideas of your own? 87 1 ☐ yes 2 ☐ no 3 ☐ not sure
13. Have you done anything outside of work that someone you admire has thought worthwhile? 88 1 ☐ yes 2 ☐ no 3 ☐ not sure
14. Do you feel as successful as the people you go with in the things you do outside of work? 89 1 ☐ yes 2 ☐ no 3 ☐ not sure
15. Are you bothered by wanting to do things you do not feel mentally or intellectually able to do? 90 1 ☐ yes 2 ☐ no 3 ☐ not sure
16. Do you feel satisfied with your present social standing? 91 1 ☐ yes 2 ☐ no 3 ☐ not sure

SKIP
92-END

PART IV – LEISURE TIME PHYSICAL ACTIVITIES

Listed below are a series of Leisure Time Activities. Related activities are grouped under general headings. Please read the list and check "yes" in column 3 for those activities which you have performed in the last 12 months, and "no" in column 2 for those you have not. Do not complete any of the other columns.

ACTIVITY (1)	Did you perform this activity?		For Clinic Personnel Use Only															
			Month of Activity												Average number of times per month	Time per occasion		DO NOT WRITE IN THIS SPACE
	No (2)	Yes (3)	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		Hours	Min.	
SECTION A: Walking and Miscellaneous																		
Walking for Pleasure and/or to Work																		015
Using Stairs When Elevator is Available																		030
Cross Country Hiking																		040
Back Packing																		050
Mountain Climbing																		060
Bicycling to Work and/or for Pleasure																		115
Dancing – Ballroom and/or Square																		125
SECTION B: Conditioning Exercise																		
Home Exercise																		150
Health Club																		160
Jogging and Walking																		180
Running																		200
Weight Lifting																		210
SECTION C: Water Activities																		
Water Skiing																		220
Sailing																		235
Canoeing or Rowing for Pleasure																		250
Canoeing or Rowing in Competition																		260
Canoeing on a Camping Trip																		270
Swimming (at least 50 ft.) at a Pool																		280
Swimming at the Beach																		295
Scuba Diving																		310
Snorkeling																		320
SECTION D: Winter Activities																		
Snow Skiing, Downhill																		340
Snow Skiing, Cross Country																		350
Ice (or Roller) Skating																		360
Sledding or Tobogganing																		370
SECTION E: Sports																		
Bowling																		390
Volley Ball																		400
Table Tennis																		410
Tennis, Singles																		420
Tennis, Doubles																		430
Softball																		440
Badminton																		450
Paddle Ball																		460

SKIP 37-END

09403
Dup 6-24

ACTIVITY (1)	Did you perform this activity? No (2)	Did you perform this activity? Yes (3)	For Clinic Personnel Use Only: Month of Activity Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Average number of times per month	Time per occasion Hours	Time per occasion Min.	DO NOT WRITE IN THIS SPACE	
SECTION E: Sports (Continued)															25	28	32		
Racket Ball																		470	SKIP 37-END
Basketball; Non-Game																		480	
Basketball; Game Play																		490	
Basketball; Officiating																		500	
Touch Football																		510	
Handball																		520	
Squash																		530	
Soccer																		540	
GOLF:																			
Riding a Power Cart																		070	
Walking, Pulling Clubs on Cart																		080	
Walking and Carrying Clubs																		090	
SECTION F: Lawn and Garden Activities																			
Mowing Lawn with Riding Mower																		550	
Mowing Lawn Walking Behind Power Mower																		560	
Mowing Lawn Pushing Hand Mower																		570	
Weeding and Cultivating Garden																		580	
Spading, Digging, Filling in Garden																		590	
Raking Lawn																		600	
Snow Shoveling by Hand																		610	
SECTION G: Home Repair Activities																			
Carpentry in Workshop																		620	
Painting inside of House, includes Paper Hanging																		630	
Carpentry Outside																		640	
Painting Outside of House																		650	
SECTION H: Fishing and Hunting																			
Fishing from River Bank																		660	
Fishing in Stream with Wading Boots																		670	
Hunting Pheasants or Grouse																		680	
Hunting Rabbits, Prairie Chickens, Squirrels, Raccoon																		690	
Hunting Large Game; Deer, Elk, Bear																		710	
SECTION I: Other Activities																			

SECTION J:

Considering all the things you do, how would you rate yourself as to the amount of physical activity you get compared with other men your age? Check one:

09404
Dup 6-24

RATACT12 1 ☐ I am much less active than others 2 ☐ I am somewhat less active than others 3 ☐ I am about the same 4 ☐ I am somewhat more active 5 ☐ I am much more active

PART V – NUTRITION

1. During the past 12 months has your personal physician (other than MRFIT physician) advised you to follow any special diet or to make any changes in the food you eat?

25 1 ☐ yes → 2 ☐ no ↓

2. Did you personally request the diet information from your physician? 27 1 ☐ yes 2 ☐ no

3. Please summarize the food changes your physician advised you to make.

_____

_____

_____

CC USE 1☐ 28

4. For each item below indicate whether it was for that reason that the physician asked you to follow the special diet.

a. Diabetes	29	1 ☐ yes 2 ☐ no
b. Overweight	30	1 ☐ yes 2 ☐ no
c. High Blood Pressure	31	1 ☐ yes 2 ☐ no
d. High Blood Fat or Cholesterol	32	1 ☐ yes 2 ☐ no
e. Food Allergy	33	1 ☐ yes 2 ☐ no
f. Ulcer	34	1 ☐ yes 2 ☐ no
g. Other	35	1 ☐ yes 2 ☐ no

Specify _____

5. Were you given printed instructions describing the special diet? 36 1 ☐ yes 2 ☐ no

6. Was the special diet explained to you by the physician or his staff?

37 1 ☐ yes → 2 ☐ no ↓

7. Check the following people who explained the diet to you.

a. Physician	38	1 ☐ yes 2 ☐ no
b. Nurse	39	1 ☐ yes 2 ☐ no
c. Dietitian or Nutritionist	40	1 ☐ yes 2 ☐ no
d. Other Staff	41	1 ☐ yes 2 ☐ no

Specify _____

8. How well did you understand the diet changes the physician advised you to make? (Check one)

42 1 ☐ Very well. I understood what changes to make 2 ☐ Fairly well. I understood some of the changes required but had further questions 3 ☐ Not very well. I didn't know what changes to make

9. Have you started making the diet changes the physician advised you to follow?

43 1 ☐ yes → 2 ☐ no ↓

10. Approximately how long has it been since you started making these diet changes?

44 1 ☐ less than one month 2 ☐ one-three months 3 ☐ four-six months 4 ☐ seven-nine months 5 ☐ ten-twelve months 6 ☐ more than twelve months

11. In general, how closely have you been following this diet during the past year?

45 1 ☐ have changed eating habits consistent with diet and very rarely go off diet 2 ☐ follow diet most of the time 3 ☐ have not been able to stick to the diet consistently

Continue with question 12.

12. During the past 12 months have you made any changes in the food you eat other than diet changes recommended by your personal physician?

46 1 ☐ yes → 2 ☐ no ↓

13. What was the **major** reason that motivated you to make these changes in the food you eat? (Check **one**)

47 1 ☐ Written information media—such as newspapers, magazines, books and ads
2 ☐ Audio-visual information media—such as radio, television
3 ☐ Advice from MRFIT staff
4 ☐ Family influence
5 ☐ Joined a nutrition education group (other than 3 above) such as Weight Watchers
Specify Group _____
6 ☐ Advice from acquaintances or friends
7 ☐ Personal concern over own health
8 ☐ Other, Specify _____

14. Approximately how long has it been since you started making these diet changes?

48 1 ☐ less than one month 2 ☐ one-three months 3 ☐ four-six months 4 ☐ seven-nine months 5 ☐ ten-twelve months 6 ☐ more than twelve months

Continue with question 15.

15. Was "Yes" checked for either question 9 or question 12?

1 ☐ yes → 16. For each of the foods listed below indicate how often you eat these foods by checking "Not at all", "Rarely", "Sometimes" or "Often".

2 ☐ no

Food Item	How often do you eat this food? (Check one)				DO NOT COMPLETE: Have you changed how much of this food you eat? (Check one)			
	Not at all (1)	Rarely (2)	Some-times (3)	Often (4)	Not at all (1)	Eat more now (2)	Eat less now (3)	Eat none now (4)
Vegetables								
Hamburger (Regular Ground Beef)								
Commercial Baked Goods								
Sausage, Bacon, or Lunch Meats								
Oils								
Butter								
Margarine								
Cheese								
Fruits								
Poultry								
Shellfish (Shrimp, Crab, Lobster, Clams, etc.)								
Sugar, (Candy, Sweetened Soft Drinks)								
Whole Milk								
Skim Milk								
Vitamin Pills								
Eggs								
Lean Meats (Low Fat)								
Cereals and Bread								
Cream or Ice Cream								
Liver, Kidney, Heart, or Brains, etc.								
Fish								
Potato Chips and Snack Crackers								
Sherbet and Water Ices								
Non-dairy Coffee Creamer								

Continue with item 17.

17. We would like you to think carefully about where and how often you ate your meals and snacks during the **past seven days.** For each meal or snack listed below please enter the **number** of days:

you ate the food AT HOME in Column A
you ate the food AWAY FROM HOME in Column B
you DID NOT EAT the food in Column C

Before completing, please note the definitions in the footnotes.

Meals	Column A** Number of days past week you ate meal or snack AT HOME	Column B*** Number of days past week you ate meal or snack AWAY FROM HOME	Column C Number of Days past week you DID NOT EAT meal or snack
Morning Meal	98 ☐	99 ☐	100 ☐
Noon Meal	101 ☐	102 ☐	103 ☐
Evening Meal	104 ☐	105 ☐	106 ☐
Snacks*			
Morning Snack or Beverage	107 ☐	108 ☐	109 ☐
Afternoon Snack or Beverage	110 ☐	111 ☐	112 ☐
Late Afternoon Snack or Beverage	113 ☐	114 ☐	115 ☐
Early Evening Snack or Beverage	116 ☐	117 ☐	118 ☐
Bedtime Snack or Beverage	119 ☐	120 ☐	121 ☐

*Definition of a snack:

Food eaten or beverages drunk at least 30 minutes before or after a meal.

Beverages such as milk, fruit or soft drinks (regular or diet variety), coffee or tea (with sugar and/or whitener), beer, wine, or cocktails count as a snack.

Plain coffee or tea do not count as a snack.

**Definition of a meal or snack eaten AT HOME, Column A:

Food or drink prepared at home.

Includes a packed lunch prepared at home and eaten at work.

***Definition of a meal or snack eaten AWAY FROM HOME, Column B:

Food or drink purchased at a restaurant, cafeteria, snack bar, delicatessen, vending machine, or take-out food store.

Includes prepared food purchased at a take-out food store and eaten at home.

Includes meals or snacks eaten at the home of friends or relatives.

Please answer the following questions about your usual pattern of drinking the following beverages: Decaffeinated coffee, coffee, tea, cola and alcoholic beverages.

18. Do you drink decaffeinated coffee (hot or iced)?

DDCAF12 122
1 ☐ yes → 19. Do you usually drink more than one cup (8 oz.) a day?
2 ☐ no

D1DCAF12 123
1 ☐ yes → 20. How many cups a day? 124 ☐☐ cups a day. DCAFD12
2 ☐ no
Go to question 22.

21. How many cups a week do you usually drink? DCAFW12 126 ☐☐ cups a week.

22. Do you drink coffee (hot or iced)?

DCOFF12 128
1 ☐ yes → 23. Do you usually drink more than one cup (8 oz.) a day?
2 ☐ no

D1COFF12 129
1 ☐ yes → 24. How many cups a day? 130 ☐☐ cups a day. COFFD12
2 ☐ no
Go to question 26.

25. How many cups a week do you usually drink? COFFW12 132 ☐☐ cups a week.

26. Do you drink tea (hot or iced)?

DTEA12 134
1 ☐ yes → 27. Do you usually drink more than one cup (8 oz.) a day?
2 ☐ no

D1TEA12 135
1 ☐ yes → 28. How many cups a day? 136 ☐☐ cups a day. TEAD12
2 ☐ no
Go to question 30.

29. How many cups a week do you usually drink? TEAW12 138 ☐☐ cups a week.

30. Do you drink cola beverages (e.g. Coke, Pepsi, Tab, Diet Pepsi, Shasta Cola)?

DCOLA12 140
1 ☐ yes → 31. Do you usually drink more than one glass (12 oz.) a day?
2 ☐ no

D1COLA12 141
1 ☐ yes → 32. How many glasses a day? 142 ☐☐ glasses a day. COLAD12
2 ☐ no
Go to question 34.

33. How many glasses a week do you usually drink? COLAW12 144 ☐☐ glasses a week.

34. Do you drink wine, beer, whiskey or liquor (cocktails, gin, vodka, scotch, bourbon, rum, etc.)?

DRKALC12 146
1 ☐ yes → 35. How often do you drink wine, beer, whiskey, or liquor (cocktails, gin, vodka, scotch, bourbon, rum, etc.)? OFTALC12
2 ☐ no

147 1 ☐ less often than once per week 2 ☐ one-four times a week 3 ☐ nearly every day 4 ☐ every day

36. When you drink alcoholic beverages, how many do you usually drink in a day?

148 ☐☐ number of drinks per day. ALCD12

Finished.

DRINKS12

SKIP 150-END