

CARDIA ID Label

MEDICAL HISTORY / WEIGHT

___ / ___ / ___
exam date

Please answer the following questions about your weight.

1. B08MAXWT pounds What is the most you have ever weighed ?
(If female, do not include weight during pregnancy.)

B08AGEWT years How old were you when you first weighed that much ?

2. B08SIZE Would you consider yourself now:
Much too thin Much too fat
_____ _____
1 2 3 4 5

3. Have you ever been on a weight reducing diet ?

B08PDIET 1 No 2 Yes

If yes, are you on such a diet now ?
1 No 2 Yes B08NDIET

4. B08TENLB times How many times would you say that you have lost and gained back 10 pounds or more ?

5. When you gain weight, where do you tend to put it on? (Check no or yes for each category.)

	NO	YES	
B08GWNEK	1 <input type="checkbox"/>	2 <input type="checkbox"/>	Neck
B08GWARM	1 <input type="checkbox"/>	2 <input type="checkbox"/>	Arms
B08GWCHS	1 <input type="checkbox"/>	2 <input type="checkbox"/>	Chest
B08GWWAS	1 <input type="checkbox"/>	2 <input type="checkbox"/>	Waist or abdomen
B08GWHIP	1 <input type="checkbox"/>	2 <input type="checkbox"/>	Hips
B08GWTHI	1 <input type="checkbox"/>	2 <input type="checkbox"/>	Thighs
B08GWBUT	1 <input type="checkbox"/>	2 <input type="checkbox"/>	Buttocks
B08GWOTH	1 <input type="checkbox"/>	2 <input type="checkbox"/>	Other

6. What is your belief about the effect of being overweight on health?

B08BLFOV Harmless Very harmful
_____ _____
1 2 3 4 5

Has a doctor or nurse ever said you had any of the following :

	NO	YES	NOT SURE		
1.01	1 <input type="checkbox"/>	2 <input type="checkbox"/>	8 <input type="checkbox"/>	High blood pressure or hypertension ?	B08HBP
1.02	1 <input type="checkbox"/>	2 <input type="checkbox"/>	8 <input type="checkbox"/>	High cholesterol ?	B08HCHOL
1.03	1 <input type="checkbox"/>	2 <input type="checkbox"/>	8 <input type="checkbox"/>	Heart problem ?	B08HEART
1.04	1 <input type="checkbox"/>	2 <input type="checkbox"/>	8 <input type="checkbox"/>	Diabetes (high sugar in blood or urine) ?	B08DIAB
1.05	1 <input type="checkbox"/>	2 <input type="checkbox"/>	8 <input type="checkbox"/>	Kidney problem ?	B08KIDNY
1.06	1 <input type="checkbox"/>	2 <input type="checkbox"/>	8 <input type="checkbox"/>	Thyroid problem ?	B08THYRD
1.07	1 <input type="checkbox"/>	2 <input type="checkbox"/>	8 <input type="checkbox"/>	Ulcer of your stomach or duodenum ?	B08ULCER
1.08	1 <input type="checkbox"/>	2 <input type="checkbox"/>	8 <input type="checkbox"/>	Liver problem ?	B08LIVER
1.09	1 <input type="checkbox"/>	2 <input type="checkbox"/>	8 <input type="checkbox"/>	Cancer or tumor ?	B08CANCER
1.10	1 <input type="checkbox"/>	2 <input type="checkbox"/>	8 <input type="checkbox"/>	Nervous, emotional or mental disorder	B08MENTL
1.11	1 <input type="checkbox"/>	2 <input type="checkbox"/>	8 <input type="checkbox"/>	Gallstones or gall bladder disease ?	B08GALL
1.12	1 <input type="checkbox"/>	2 <input type="checkbox"/>	8 <input type="checkbox"/>	Sickle cell trait ?	B08SIKLE
1.13	1 <input type="checkbox"/>	2 <input type="checkbox"/>	8 <input type="checkbox"/>	Any other major disease or health problem ?	B080THDZ
4.00	1 <input type="checkbox"/>	2 <input type="checkbox"/>	8 <input type="checkbox"/>	Have you ever taken medication for high blood pressure ?	B08BPMED
4.01	1 <input type="checkbox"/>	2 <input type="checkbox"/>	8 <input type="checkbox"/>	Have you ever taken medication for a heart condition ?	B08HRMED
4.04	1 <input type="checkbox"/>	2 <input type="checkbox"/>	8 <input type="checkbox"/>	Do you take medicine for asthma or any other breathing problem ?	B08ASMA
4.05	1 <input type="checkbox"/>	2 <input type="checkbox"/>	8 <input type="checkbox"/>	Are you currently taking any other prescription medications ?	B080TMED

MEDICAL HISTORY / MALE

B08VASEC
2.00

	NO	YES	NOT SURE
1	<input type="checkbox"/>	2 <input type="checkbox"/>	8 <input type="checkbox"/>

Have you had a vasectomy ?

B08IVID __ INTERVIEWER ID