

**ACTIVITY COUNSELING TRIAL
DEMOGRAPHICS AND MEDICAL HISTORY**

Participant Name

The questions that follow will ask for some information about your general background as well as your health history. Please answer them as completely as possible. It should take 15 to 20 minutes to finish. After you have completed the questionnaire, a clinic staff member will go over it with you. If you have any questions or concerns about your answers, please share them with the staff member at that time.

7. Have you ever been diagnosed or treated for any types of cancer other than skin cancer?

OTHCANC

1 Yes

"What kind of cancer?" _____

"Was this within the last 5 years?" 1 Yes 2 No

2 No

8. Has a doctor ever told you that you have had a heart attack? 1 Yes 2 No

HRTPROB - VARIABLE FOR BOTH QUESTIONS 8 AND 9

9. Has a doctor ever told you that you have any of the following conditions?

a) Angina (chest pain from a heart problem) requiring treatment with medications

1 Yes 2 No

b) Heart failure or congestive heart failure

1 Yes 2 No

c) Heart rhythm problem (irregular heartbeat)

1 Yes 2 No

d) Heart conduction problem (heart block)

1 Yes 2 No

e) Heart valve problem

Specify type of valve problem:

1 Yes

2 No

10. Have you ever had any of the following surgical procedures?

a) Surgery for blocked or clogged arteries in your heart

1 Yes 2 No

b) Balloon angioplasty for your heart (opening the arteries of the heart with a balloon or other device, sometimes called a PTCA)

1 Yes 2 No

c) Heart valve replacement* **VALVEREP**

1 Yes 2 No

OTHCOND - VARIABLE FOR BOTH QUESTIONS 10 AND 11

11. Has a doctor ever told you that you have had a stroke or TIA (mini-stroke)?

1 Yes 2 No

12. Are you currently taking any of the following medications:

a) Heparin or Coumadin?

1 Yes 2 No

b) Steroids by mouth?

1 Yes 2 No

13. Has a doctor ever told you that you have high cholesterol or an abnormally high level of fats in your blood? **HIGHCHOL**

Yes — Are you now taking any medications to treat it? **CHOLMEDS** Yes No
 No

14. Has a doctor ever told you that you have a blood circulation problem in any of the following areas?

- a) In your head or neck? **HDOTHCRC** Yes No
- b) In your legs or feet? **LEGCIRC** Yes No
- c) In any other area of your body?

Yes — Specify area:
 No

15. Has a doctor ever told you that you have asthma? *#15-Yes = automatic exclusion*

ASTHMA

Yes — Do you currently take medications for your asthma on a daily basis?
 Yes No

Yes — Do physical activities such as walking, running, swimming and playing sports cause you to have asthma attacks?
 Yes No

No

16. Do you have any of the following problems?

- a) Rheumatoid arthritis **ARTHRITIS** - VARIABLE FOR A & B Yes No
- b) Psoriatic arthritis Yes No
- c) Reiter's Disease **DISEASE** - VARIABLE FOR C THROUGH G Yes No
- d) Lupus or SLE Yes No
- e) Parkinson's Disease Yes No
- f) Emphysema Yes No
- g) Chronic obstructive lung disease Yes No

17. Has a doctor ever told you that you have kidney disease? **KIDNYDIS**

Yes — Please specify what kind:
 No

18. Has a doctor ever told you that you have liver disease?

LIVERDIS

1 Yes

Please specify what kind:

2 No

19. Have you been treated in the last 5 years by a health care professional for any of the following?

a) Major depression

ANYDEP - VARIABLE FOR A THROUGH C

1 Yes 2 No

b) Manic depressive illness

1 Yes 2 No

c) Schizophrenia

1 Yes 2 No

20. Are you currently taking any of the following medications for depression or other psychiatric illness?

a) Antimanic drugs, such as lithium?

1 Yes 2 No

b) Antipsychotic drugs or tranquilizers, such as thorazine or haldol?

1 Yes 2 No

c) Antidepressants, such as prozac or elavil?

1 Yes 2 No

21. Have you been hospitalized in the last 5 years for major depression?

#21 - automatic exclusion

1 Yes 2 No

22. Are you currently under a doctor's care for any medical problems not listed on the previous pages? **DRCARE**

Please describe those problems in the space below:

1 Yes

2 No

23. The following questions are about your weight. [WOMEN: We are interested in your weight at times other than when you were pregnant.]

(a) Is your current weight 5 or more pounds different (*lighter or heavier*) from what it was 6 months ago? **WTDIFF5**

1 Yes, **gained** more than 5 pounds.

(i) How many pounds have you gained? pounds **MLBGAINS**

(ii) Did you try to gain this weight? **MTRYGAIS** Yes 2 No

2 Yes, **lost** more than 5 pounds.

(i) How many pounds have you lost? pounds **MLBLOST5**

(ii) Did you try to lose this weight **MTRYLOSS** Yes 2 No

3 No 9 Don't know

(b) How many times in your life have you lost at least 10 pounds and then gained it back? If you have never lost and gained back 10 pounds, enter zero ("00"). (WOMEN: do not include times when you were pregnant.)

LS10GN10 times

24. The following questions are about alcohol use.

(a) In **any one year**, have you ever had 12 or more drinks containing alcohol?
1 Yes 2 No (please skip to question 25) **DRKSYR**

(b) In **the last 12 months**, have you had 12 or more drinks containing alcohol?
1 Yes (please answer parts c, d, and e below) **DRKS12**
2 No (please skip to question 25)

(c) During a typical week, how many cans or bottles of beer do you drink? (Remember to include weekends.)
 bottles per week **BEERCNT**

(d) During a typical week, how many glasses of wine do you drink? (Remember to include weekends.)
 glasses per week **WINECNT**

(e) During a typical week, how many mixed drinks or shots of liquor do you drink? (Remember to include weekends.)
 shots per week **LIQORCNT**

26. What is your current employment status? **EMPSTAT**

(please indicate the **one** that best describes you now)

- 1 Unemployed
- 2 Full-time homemaker
- 3 Employed full-time or part-time
- 4 Permanently disabled
- 5 Retired
- 6 Full-time or part-time student
- 7 On temporary medical leave

27. In the spaces provided below, please write your current **job title** and **briefly describe your occupation**. (If you are retired or currently unemployed, please give the title and description of your most recent job. If you are a full-time homemaker who has never been employed outside the home, please write "homemaker" in both spaces.)

Example
<p>A fourth grade teacher of an elementary public school might respond:</p> <p>Job Title: <u>teacher</u></p> <p>Occupation: <u>teach fourth grade in public elementary school</u></p>

Job Title: _____

Occupation: _____

How many years have you worked (or did you work) at this job? years

OCCUP_YR

28. Which of the following categories best describes your annual household income? (Please select only one category.) **H_INCOME**

- 1 Less than \$5,000
- 2 \$5,000 to \$9,999
- 3 \$10,000 to \$14,999
- 4 \$15,000 to \$19,999
- 5 \$20,000 to \$24,999
- 6 \$25,000 to \$29,999
- 7 \$30,000 to \$34,999
- 8 \$35,000 to \$45,999
- 9 \$46,000 to \$49,999
- 10 \$50,000 to \$74,999
- 11 \$75,000 to \$99,999
- 12 \$100,000 or more

Is your response based on the take home amount? **H_AMOUNT** 1 Yes 2 No

How many people are currently living in your household (including yourself)?

HOUSECNT

29. Which of the following categories best describes your annual **personal income**? (Please select only one category.)

P_INCOME

- | | | |
|---|---|--|
| 1 <input type="checkbox"/> Less than \$5,000 | 5 <input type="checkbox"/> \$20,000 to \$24,999 | 9 <input type="checkbox"/> \$46,000 to \$49,999 |
| 2 <input type="checkbox"/> \$5,000 to \$9,999 | 6 <input type="checkbox"/> \$25,000 to \$29,999 | 10 <input type="checkbox"/> \$50,000 to \$74,999 |
| 3 <input type="checkbox"/> \$10,000 to \$14,999 | 7 <input type="checkbox"/> \$30,000 to \$34,999 | 11 <input type="checkbox"/> \$75,000 to \$99,999 |
| 4 <input type="checkbox"/> \$15,000 to \$19,999 | 8 <input type="checkbox"/> \$35,000 to \$45,999 | 12 <input type="checkbox"/> \$100,000 or more |

Is your response based on the take home amount? Yes No

P_AMOUNT

30. Please indicate below the source(s) of **your own personal income** (not household income) by marking the primary source with a "1". If you have more than one source of income, mark the second source with a "2", the third source with a "3", and so on.

- Employment (as listed above in question 26)
- Governmental (Older Americans Supplemental Disability Income (OASDI), Railroad Retirement, Social Security Benefits, Supplemental Security Income (SSI), Veterans Benefits, Aid to Families with Dependent Children (AFDC), or General Assistance from Local or State governments)
- Retirement (pensions, annuities, etc.)
- Unemployment Compensation
- Interest and Dividends
- Other (alimony, child support, etc.)

MEN: Please stop here. Thank you for taking time to complete the form. If you have any questions or concerns about any of your answers, please tell the clinic staff person when you return the questionnaire.

Women: Please answer the questions on the following pages.

31. Are you pregnant or currently trying to get pregnant? Yes No **CIGARS**
32. Do you plan to try to get pregnant during the next 2 years? Yes No
33. The following questions are about your menstrual cycles.

(a) Have you undergone menopause (change of life)? **MENOPAUS**

Yes

No Unsure

Were you pregnant or breast feeding within the last year?

Yes

Are you currently pregnant? Yes No

Are you currently breastfeeding? Yes No

No

(b) When was the first day of your last menstrual period?

Mon Day Year

If your last menstrual period was less than 12 months ago, please answer the questions in the box below.

How many periods have you had in the last 12 months? **PERIOD12** periods

About how many days apart are your periods? **DAYAPART** days

Are your periods usually regular or irregular? regular irregular **REGIRREG**

(c) Have you had a hysterectomy or surgery to remove your uterus or womb? **UTERWOMB**

Yes — At what age? years **AGESURE**

No Unsure

(d) Have you had surgery to remove your ovaries? **OVARIES**

Yes

How many ovaries were removed? one both unsure **OVARYCNT**

At what age? years **OVARYAGE**

No Unsure

33. Menstrual history (continued, women only).

STOPMENS

(e) Have you had any other condition or treatment that caused your menstrual periods to permanently stop, other than the surgeries listed above or natural menopause?

Yes

Please specify the condition or treatment:

How old were you when this occurred? years

STOP_AGE

No

Thank you for taking time to complete this form. If you have any questions or concerns about any of your answers, please tell the clinic staff person when you return the questionnaire.