Provider Baseline Questionnaire

Site ID
Provider ID

____
Date form completed

1. Please indicate <u>the percentage of adult patient ***visits***</u> in which you (or your staff) do each of the following related to weight management in your practice?

For <u>what percent of patient visits</u> do you:	**0-9%**	**10-24%**	**25-49%**	**50-74%**	**75-100%**
a) Measure height					
b) Measure weight					
c) Measure waist circumference					
d) Calculate BMI					

2. Please indicate <u>the percentage of obese adult ***patients***</u> (i.e. BMI $\geq$ 30 kg/m^2) in which you do each of the following related to weight management in your daily practice?

For <u>what percent of obese patients</u> do you:	**0-9%**	**10-24%**	**25-49%**	**50-74%**	**75-100%**
a) Discuss weight management					
b) Assess the patients' motivation to lose weight					
c) Discuss specific dietary recommendations related to losing or maintaining weight					
d) Provide behavioral counseling and help set goals					
e) Discuss specific physical activity recommendations related to losing or maintaining weight					
f) Refer to a dietician, nutritionist or counselor <u>within your practice</u>					
g) Refer to a dietician, nutritionist or counselor <u>outside your practice</u>					
h) Refer to a commercial weight loss program (e.g. Weight Watchers)					
i) Refer to another type of weight loss program					
j) Prescribe a weight loss medication					
k) Refer for bariatric surgery (if eligible, such as BMI $\geq$ 40 kg/m^2)					

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Please provide the following **BACKGROUND INFORMATION about yourself:**

3. What is your current age? ____
4. What is your gender? ___ Male ___ Female
5. Are you Hispanic or Latino? ___ Yes __ No
6. Which of the following groups would you say best represents your race? (Select one or more.)

   __ American-Indian or Alaskan Native
   __ Asian
   __ Black or African-American
   __ Native Hawaiian or Other Pacific Islander
   __ White
   __ Other **(Specify):**________________________

7. What is your specialty?

   ___ General Internal Medicine ___ Family Practice ___ Medicine/Pediatrics ___ General Practice

   ___ Internal Medicine Subspecialty (specify) ___________________

8. What is the highest medical degree you have obtained?

   ____ MD ______ NP ____ PA _____ BSN ____ RN

   ____ LPN ______ MA ____ Other (specify): ________________ ___ None

9. In what year did you receive this degree? ________ Not applicable
10. How many years have you been a part of this practice? ___
11. How many years have you been in practice total? ___
12. Please indicate the **number of hours per week** you spend in each of the following. (Indicate 0 hours if none in a particular area.)
    a) Clinical Care ____ b) Teaching ____ c) Research ___ d) Administration ___
13. Prior to this study (POWER Trial), have you ever participated in research as an investigator?
    ___ Yes __ No
14. How would you rate your overall knowledge about addressing weight and weight management issues with patients?
    __ Minimal __ Beginner __ Intermediate __ Advanced
15. What is your current weight? ______ pounds
16. What is your current height? _______feet ______ inches