

Paste identification tag

IDENTIFICATION DATA

CODE:DATE: GROUP:

NAME: LAST NAME(S):

ADDRESS:ZIP CODE:.....TOWN/ CITY:STATE:

PHONE:DATE OF BIRTH: CURRENT AGE: MALE FEMALE

COUNTRY OF BIRTH:ETHNICITY:INTERVIEWER:

EXCLUSION CRITERIA

	Indicate whether any of the criteria are met:
1- Do you currently live in a hospital, nursing home or assisted living center? 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> NO 9 <input type="checkbox"/> ns, nc*	<input type="checkbox"/> EXCLUDED
2- Are you pregnant? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 9 <input type="checkbox"/> ns, nc	<input type="checkbox"/> EXCLUDED
3- Have you had a child in the last 6 months? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 9 <input type="checkbox"/> ns, nc	<input type="checkbox"/> EXCLUDED
4- Have you undergone any major surgery in the last month? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 9 <input type="checkbox"/> ns, nc	<input type="checkbox"/> EXCLUDED
5- Have you suffered any serious illnesses not related to diabetes in the last 6 months? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 9 <input type="checkbox"/> ns, nc	<input type="checkbox"/> EXCLUDED

*ns, nc: does not know; does not answer

If excluded, go to page 4: Known diabetes, hypertension and cardiovascular disease

SOCIAL STATUS

<p>6- Civil status</p> <p>1 <input type="checkbox"/> Single</p> <p>2 <input type="checkbox"/> Married OR domestic partnership</p> <p>3 <input type="checkbox"/> Widowed</p> <p>4 <input type="checkbox"/> Divorced</p> <p>9 <input type="checkbox"/> ns / nc</p>	<p>7- What is your highest level of studies attained?</p> <p>1 <input type="checkbox"/> Cannot read/write</p> <p>2 <input type="checkbox"/> No formal schooling</p> <p>3 <input type="checkbox"/> Primary education (up to 12 years)</p> <p>4 <input type="checkbox"/> Secondary education (16 years)</p> <p>5 <input type="checkbox"/> Bachelor, technical training (18 years)</p> <p>6 <input type="checkbox"/> University first cycle studies (associate's degree program)</p> <p>7 <input type="checkbox"/> University second cycle studies (undergraduate degree program, engineering, medicine)</p> <p>9 <input type="checkbox"/> ns / nc</p>	<p>8- Do you have a job?</p> <p>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 9 <input type="checkbox"/> ns / nc</p> <p>9- If you do not work, what is the reason?</p> <p>1 <input type="checkbox"/> Retired</p> <p>2 <input type="checkbox"/> Unemployed</p> <p>3 <input type="checkbox"/> Sick leave</p> <p>4 <input type="checkbox"/> Student</p> <p>5 <input type="checkbox"/> Housewife</p> <p>9 <input type="checkbox"/> ns / nc</p>						
<p>10- What is your current occupation or what was your main occupation for the majority of your life? Explain</p> <table border="0"> <tr> <td data-bbox="257 946 1227 1013"> <p>1 <input type="checkbox"/> Executives of public or private companies with 10 or more employees. Professions associated with university second cycle or postgraduate studies.</p> </td> <td data-bbox="1339 946 1682 973"> <p>4 <input type="checkbox"/> Skilled manual workers.</p> </td> </tr> <tr> <td data-bbox="257 1023 992 1129"> <p>2 <input type="checkbox"/> Directors of companies with fewer than 10 employees. Professions associated with university first cycle studies. Senior Technicians. Artists and athletes.</p> </td> <td data-bbox="1339 983 1749 1013"> <p>5 <input type="checkbox"/> Semi-skilled manual workers.</p> </td> </tr> <tr> <td data-bbox="257 1139 1059 1286"> <p>3 <input type="checkbox"/> Administrative employees, management and support personnel. Workers in personal services and security. Free-lance workers. Supervisors of manual workers.</p> </td> <td data-bbox="1339 1023 1704 1093"> <p>6 <input type="checkbox"/> Unskilled workers. 7 <input type="checkbox"/> Other (clergy, military, ...).</p> </td> </tr> </table>			<p>1 <input type="checkbox"/> Executives of public or private companies with 10 or more employees. Professions associated with university second cycle or postgraduate studies.</p>	<p>4 <input type="checkbox"/> Skilled manual workers.</p>	<p>2 <input type="checkbox"/> Directors of companies with fewer than 10 employees. Professions associated with university first cycle studies. Senior Technicians. Artists and athletes.</p>	<p>5 <input type="checkbox"/> Semi-skilled manual workers.</p>	<p>3 <input type="checkbox"/> Administrative employees, management and support personnel. Workers in personal services and security. Free-lance workers. Supervisors of manual workers.</p>	<p>6 <input type="checkbox"/> Unskilled workers. 7 <input type="checkbox"/> Other (clergy, military, ...).</p>
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SMOKING HABITS

PHYSICAL ACTIVITY

<p>11- Do you smoke? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> ns/nc</p> <p>12- How many cigarettes do you smoke?/day</p> <p>13- At what age did you start smoking?</p> <p>14- Have you changed your smoking habits in the last 6 months? 1 <input type="checkbox"/> Yes, I smoke more 3 <input type="checkbox"/> Yes, I smoke less 2 <input type="checkbox"/> NO 9 <input type="checkbox"/> ns / nc</p> <p><u>IF NOT CURRENTLY A SMOKER</u></p> <p>15- Have you ever smoked more than 1 cig./day at some point during your life? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> ns/nc</p> <p>16- How much did you use to smoke?</p> <p>17- At what age did you quit smoking?</p> <p>18- At what age did you start smoking?</p>	<p>19- How many hours do you usually sleep? hours / day</p> <p>20- Which of these options best describes your main activity during the day, while at work, school, or home? 1 <input type="checkbox"/> Sitting most of the day 2 <input type="checkbox"/> Standing most of the day without significant movement and/or effort 3 <input type="checkbox"/> Walking, carrying some weight, or making frequent trips that do not require great physical effort 4 <input type="checkbox"/> Performing tasks that require a great amount of physical effort</p> <p>21- In your free time, do you usually perform heavy physical exercise at least once a week? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> ns / nc</p> <p>If the answer is yes:</p> <p>22- How many days a week?days</p> <p>23- On the days that you exercise, for how long do you exercise? hours</p> <p>24- What kind of exercise do you do?</p>
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HISTORY OF DIABETES

<p>25 - Have you ever been told by a doctor that you had diabetes? (sugar in blood) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> ns/nc</p> <p>26- If yes, how old were you at the time of diagnosis?years old</p> <p>27- Do any of your relatives (parents, siblings, children, or grandparents) have diabetes? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> ns/nc</p> <p>Specify how many:</p> <p>28- Grandparents:</p> <p>29- Parents:</p> <p>30- Uncles and aunts:</p> <p>31- Brothers and sisters:</p> <p>32- Children:</p>	<p>33- Do you take any pills for diabetes? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> ns/nc</p> <p>34- If yes, for how long have you been taking them?years</p> <p>35- Are you injecting insulin? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> ns/nc</p> <p>36- If yes, for how long have you been injecting insulin?years</p> <p>37- Have you ever been on a diet for your diabetes, as guided by your doctor? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> ns/nc</p> <p>38- If yes, for how long have you been following the diet?years (If not following any diet for diabetes, mark 77.)</p>
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HISTORY OF ARTERIAL HYPERTENSION

<p>39- Have you ever been told by a doctor that you had high blood pressure? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> ns/nc</p> <p>40- If yes, how old were you when he/she told you that you had hypertension?years old</p> <p>41- Do you take any medication for hypertension? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> ns/nc</p> <p>42- If yes, for how long have you been taking it?years</p> <p>43- Have you taken it in the last 24 hours? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> ns/nc</p>

CARDIOVASCULAR AND OTHER DISEASES

44- Have you ever been told by a doctor that you had high cholesterol?

1 Yes 2 No 9 ns/nc

45- Have you been told by a doctor that you have suffered a heart attack, angina or myocardial infarction?

1 Yes 2 No 9 ns/nc

46- Have you been told by a doctor that you have suffered a stroke, cerebral hemorrhage or cerebral palsy?

1 Yes 2 No 9 ns/nc

47- Have you ever been told by a doctor that you have peripheral vascular disease (foot ulcers)?

1 Yes 2 No 9 ns/nc

48- Have you been told by a doctor that you suffer from a chronic disease (bronchitis, asthma, rheumatism, tumors etc)?

1 Yes 2 No 9 ns/nc

49-If you answered yes to any of the above questions, explain:

<p>Drugs that you regularly take, including vitamins, analgesics, tranquilizers, ... etc. (Not including herbal products)</p> <p>50.....</p> <p>51.....</p> <p>52.....</p> <p>53.....</p> <p>54.....</p>	<p>55.....</p> <p>56.....</p> <p>57.....</p> <p>58.....</p> <p>59.....</p>
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GYNECOLOGICAL HISTORY

60- How many childbirths have you had? Weights of children at birth:kg,kg,kg,kg,kg,kg,

61- Were any of your pregnancies interrupted? If so, how many?

62- Had your doctor ever told you that you had gestational diabetes?

1 Yes 2 No 9 ns/nc

63- If yes, in how many pregnancies?

64- How old were you when you had your first menstrual period? years old

65- Do you use hormonal contraceptives? (Oral or patch)

1 Yes 2 No 9 ns/nc If yes, which one do you use?

66- If yes, for how long have you been taking them (regardless of how many times the composition may have been changed)? years

67- What was the date of your last menstrual period?

68- If you have had amenorrhea (lack of menstrual period) for 6 months or longer, what was the cause?

1 Natural 2 Surgical ns/nc

69- Are you on treatment for menopause?

1 Yes 2 No 9 ns/nc

70- If yes, specify:

71- If yes, for how long have you been on this treatment (regardless of how many times the composition may have been changed)? years

WEIGHT CHANGES

ANTHROPOMETRICS AND BLOOD PRESSURE

72- Do you remember how much you weighed at age 18?

73- Do you weigh more now than when you were 18?
1 Yes 2 No, the same 3 No, less weight 9 ns/nc

74- Have you lost weight in the past year?
1 Yes 2 No 9 ns/nc

75- If yes, how many kg you have you lost? kg

76- Was this loss involuntary?
1 Yes 2 No 9 ns/nc

77- Have you gained weight in the past year?
1 Yes 2 No 9 ns/nc

78- If yes, how many kg did you gain? kg

79- Would you like to ...?
1 Gain Weight 2 Lose Weight 3 Maintain the same weight

80- In your opinion you are:
1 Thin 2 Normal
3 Overweight 4 Obese 9 ns/nc

81- Weight: kg

82- Height:cm

83- Waist :cm

84- Hip:cm

85- Systolic blood pressure 1:mmHg

86- Diastolic blood pressure 1:mmHg

87- Systolic blood pressure 2:mmHg

88- Diastolic blood pressure 2:mmHg

If the values show a difference of >5 mmHg, a 3rd measurement will be taken:

89- Systolic blood pressure 3:mmHg

90- Diastolic blood pressure 3:mmHg

91- If any measurement cannot be taken, indicate which and why:

.....

OBSERVATIONS

DIETARY HABITS

92- Have you changed the amount you use to eat in the last 6 months?

- 1 Yes, I eat more 3 Yes, I eat less
2 No, I eat the same 9 ns/nc

93- Have you changed the type of food in your diet over the past 6 months?

- 1 Yes 2 No 9 ns/nc

94- If yes, specify the change:

95- If yes, was the change recommended by a doctor or dietitian?

- 1 Yes 2 No 9 ns/nc

96- If you are on a diet, specify what kind of diet you are following:

.....
.....

97- How many times do you eat out per week?

- 1 daily 4 once per week
2 from 6 to 4 per week 5 3 to 2 times a month
3 from 3 to 2 per week 6 once a month
7 seldom

98- Do you take any kind of vitamin supplement?

- 1 Yes 2 No 9 ns / nc, **If yes, specify:**

99- Do you use saccharin or any kind of non-caloric sweetener?

- 1 Yes 2 No 3 ns/nc 100- Specify

100.B- Do you usually use fructose?

- 1 Yes 2 No 3 ns/nc

100.C- What type of salt do you use?

- 1 Iodized 2 Sea 3 Others 4 ns/nc

101- How many meals you usually have in a typical day?

- 1 less than 3 3 4 or 5
2 3 4 more than 5

102- Do you snack between meals?

- 1 Yes 2 No 3 Sometimes 9 ns/nc

103- Do you eat while watching TV?

- 1 Yes 2 No 3 Sometimes 9 ns/nc

104- What do you eat while watching TV?

- 1 Meals
2 Snacks
3 Both

In each row, mark the box that best describes how often each type of food is consumed:

		PER DAY					PER WEEK			PER MONTH		SELDOM OR NEVER
		5 times or more	4 times	3 times	2 times	1 time	4-6 times	2-3 times	1 time	2-3 times	1 time	
105-	Breakfast cereals											
106-	Whole grain breakfast cereals											
107-	White bread											
108-	Whole wheat bread											
109-	White rice, pasta or couscous											
110-	Brown rice or whole wheat pasta or couscous											
111-	Sugar, honey, candies, jams											
112-	Chocolate											
113-	Sweets, cakes, muffins, cookies, donuts											

	PER DAY					PER WEEK			PER MONTH		SELDOM OR NEVER
	5 times or more	4 times	3 times	2 times	1 time	4 - 6 times	2 - 3 times	1 time	2 - 3 times	1 time	
114- Eggs											
115- Milk, yogurt, cheese											
116- Milk shakes, flan, custard, ice cream											
117- Cream, butter											
118- Margarine											
119- Mayonnaise											
120- Homemade fried food											
121- Precooked foods (fried / frozen)											
122- Other precooked dishes (including pizza)											

In each row, mark the box that best describes how often each type of food is consumed:

	PER DAY					PER WEEK			PER MONTH		SELDOM OR NEVER
	5 times or more	4 times	3 times	2 times	1 time	4 - 6 times	2 - 3 times	1 time	2 - 3 times	1 time	
123- Salads (raw vegetables)											
124- Vegetable side*											
125- Vegetables in stew**											
126- Legumes											
127- Potato: stewed, boiled or fried at home (NO crisps).											
128- Fruits / natural juices											
129- Nuts and similar											
130- Appetizers: cheese puffs, corn snack food, popcorn etc.											
131- Fish / fresh seafood											
132- Canned fish / seafood											
133- Meat, pork, beef, chicken...											
134- Cured, dry sausages, ham											

*Side = vegetable(s) that is/are consumed as such, as a main dish or accompanying a 2nd course, but not used to prepare stews, sautees, etc.

** Vegetables consumed with lentils, stews, stir-fries, etc., and of which only a small amount is used in each dish.

What kind of oil do you usually use? (Multiple answers may be marked for each item.)

	1- Olive oil	2- Linoleic sunflower	3- High oleic sunflower	4- Others
135- To season (salads, etc)				
136- To stew				
137- To fry				
138- To prepare mayonnaise				

ALCOHOLIC BEVERAGES

	PER DAY					PER WEEK			PER MONTH		SELDOM OR NEVER
	5 times or more	4 times	3 times	2 times	1 time	4 - 6 times	2 - 3 times	1 time	2 - 3 times	1 time	
139- Red Wine											
140- White wine, sparkling wine											
141- Rose wine											
142- Dessert wine											
143- Beer											
143b- Cider											
144- Distilled spirits											
145- When you drink alcohol? 1 <input type="checkbox"/> With meals 2 <input type="checkbox"/> Without food/meals					3 <input type="checkbox"/> Both 9 <input type="checkbox"/> ns/nc		146- Frequency 1 <input type="checkbox"/> Daily or almost daily 2 <input type="checkbox"/> On weekends 3 <input type="checkbox"/> occasionally 4 <input type="checkbox"/> never 9 <input type="checkbox"/> ns/nc				

NON-ALCOHOLIC BEVERAGES

	PER DAY					PER WEEK			PER MONTH		SELDOM OR NEVER
	5 times or more	4 times	3 times	2 times	1 time	4 - 6 times	2 - 3 times	1 time	2 - 3 times	1 time	
147- Beer without alcohol											
148- Beverages with added sugar											
149- Beverages with no added sugar (light or diet)											
150- Commercial juices											
151- Caffeinated soft drinks											
152- Espresso											
153- Brewed coffee											
154- Instant coffee											
155- Decaffeinated brewed coffee											
156- Decaffeinated instant coffee											
157- Tea (specify)											
158- Other infusions (specify)											

159- Is the person who normally prepares the consumed foods/beverages present at the time of the interview? 1 Yes 2 No 9 ns/nc

INTERVIEWER'S NOTES:

160- Level of interest: 1 High 2 Average 3 Low

161- Accuracy in answering: 1 Good 2 Fair 3 Poor

QUALITY OF LIFE QUESTIONNAIRE (Questionnaire SF-12) (TRANSLATED FROM THE SPANISH VALIDATED VERSION)

The following questions refer to your perception of health and well-being. Your answers will enable us to know how capable you see yourself of performing routine activities. If you are not sure how to answer a question, choose the most appropriate answer from the options provided.

162- In general, you would say that your health is:

1 Excellent 2 Very good 3 Good 4 Fair 5 Poor

Read to the subject: The following questions are about activities that you might do during a typical day. Does your health currently limit your capacity to perform these activities? If so, how much?

163- Moderate activities, such as moving a table, pushing a vacuum cleaner or walking 1 hour

1- YES, very limited 2- YES, somewhat limited 3- NO, not limited at all

164- Climbing several flights of stairs.

1- YES, very limited 2- YES, somewhat limited 3- NO, not limited at all

Read to the subject: During the past 4 weeks, have you had any of the following problems performing work or other regular daily activities, as a result of your physical health?

165- Accomplished less than you would like. 1 Yes 2 No

166- Limited in the kind of work or other activities performed. 1 Yes 2 No

Read to the subject: *During the past 4 weeks, have you had any of the following problems performing work or other regular daily activities, as a result of **emotional problems** (such as feeling depressed or anxious)?*

167- Accomplished less than you would like. 1 Yes 2 No

168- Performed work or activities with less care than usual. 1 Yes 2 No

169- During the past 4 weeks, did you have any pain? Yes No

169.B During the past 4 weeks, how much did your pain interfere with your normal work (including work other than housework)?

1 Not at all 2 A little bit 3 Some 4 Quite a bit 5 A lot

Read to the subject: *These questions are about how you have been feeling during the past 4 weeks.*

For each question, please give the one answer that best reflects the way you have been feeling.

*How much of the time **during the past 4 weeks**...*

170- Have you felt calm and peaceful?

1 All the time 2 Most of the time 3 A good bit of the time 4 Some of the time 5 A little of the time 6 None of the time

171- Did you have a lot of energy?

1 All the time 2 Most of the time 3 A good bit of the time 4 Some of the time 5 A little of the time 6 None of the time

172- Have you felt discouraged and/or upset?

1 All the time 2 Most of the time 3 A good bit of the time 4 Some of the time 5 A little of the time 6 None of the time

173- During the past 4 weeks, how much of your time has your physical health or emotional problems interfered with social activities (like visiting friends, relatives, etc.)?

1 All the time 2 Most of the time 3 A good bit of the time 4 Some of the time 5 A little of the time 6 None of the time

PHYSICAL ACTIVITY QUESTIONNAIRE (IPAQ)

Read to the subject: *Now I'll ask you about the time you spent being physically active during the last 7 days. Please answer each question even if you consider yourself to be an inactive person. Think about the activities you do at work, around the house and in the yard, to get from place to place, and in your spare time, for recreation, exercise or sport.*

Read the subject: *Now, think about all the vigorous activities that you did during the last 7 days. Vigorous physical activities refer to activities that take hard physical effort and make you breathe much harder than normal. Think only about those physical activities that you did for at least 10 minutes at a time.*

174- During the last 7 days, on how many days did you do vigorous physical activities?

- _____ Days per week [VDAY; Range: 0 - 7, 8 ,9]
8. Does not know / is not sure
9. Refuses to answer

Interviewer clarification: *Think only about those physical activities that you do for at least 10 minutes.*

Interviewer Note: *If respondent answers zero, refuses to answer or does not know, skip to question 176.*

175- How much time did you usually spend doing vigorous physical activities on one of those days?

- __ __ Hours per day [VDHRS; Range: 0-16]
 __ __ __ Minutes per day [VDMIN; Range: 0-960, 998, 999]
 998. Does not know / is not sure
 999. Refuses to answer

Interviewer clarification: *Think only about those physical activities that you do for at least 10 minutes.*

Interviewer note: *We are looking for an average amount of time per day. If the respondent cannot answer because the amount of time varies from day to day, ask: "How long did you spend total performing vigorous physical activities during the last 7 days?"*

- __ __ Hours per week [VWHRS; Range: 0-112]
 __ __ __ Minutes per week [VWMIN; Range: 0-6720, 9998, 9999]
 9998. Does not know / is not sure
 9999. Refuses to answer

Read the subject: *Now think about all the moderate activities that you did in the last 7 days. Moderate activities refer to activities that take moderate physical effort and make you breathe somewhat harder than normal. Think only about those physical activities that you did for at least 10 minutes at a time.*

176- During the last 7 days, on how many days did you do moderate physical activities?

- __ Days per week [MDAY; Range: 0-7, 8, 9]
 8. Does not know / is not sure
 9. Refuses to answer

Interviewer clarification: *Think only about those physical activities that you do for at least 10 minutes.*

Interviewer Note: *If respondent answers zero, refuses or does not know, skip to question 178.*

177- How much time did you usually spend doing moderate physical activities on one of those days?

- ___ Hours per day [MDHRS; Range: 0-16]
 ___ Minutes per day [MDMIN; Range: 0-960, 998, 999]
 998. Does not know / is not sure
 999. Refuses to answer

Interviewer clarification: *Think only about those physical activities that you do for at least 10 minutes.*

Interviewer note: *An average amount of time per day on one of the days on which you did moderate physical activity is needed. If the respondent cannot answer because the amount of time varies from day to day, or includes time spent in different jobs, ask: "How much time did you devote to doing moderate physical activity during the last 7 days"?*

- ___ Hours per week [MWHRS; Range: 0-112]
 ___ Minutes per week [MWMIN; Range: 0-6720, 9998, 9999]
 9998. Does not know / is not sure
 9999. Refuses to answer

Read the subject: *Now think about the time you spent walking in the last 7 days. This includes at work and at home, walking to travel from place to place, and any other walking that you have done solely for recreation, sport, exercise, or leisure.*

178- During the last 7 days, on how many days did you walk for at least 10 minutes at a time?

- ___ Days per week [WDAY; Range: 0-7, 8, 9]
 8. Does not know / is not sure
 9. Refuses to answer

Interviewer clarification: *Think only about the walking that you did for at least 10 minutes at a time.*

Interviewer Note: *If respondent answers zero, refuses or does not know, skip to question 180.*

179- How much time did you typically spend walking on one of those days?

- ___ Hours per day [WDHRS; Range: 0-16]
 ___ Minutes per day [WDMIN; Range: 0-960, 998, 999]
 998. Does not know / is not sure
 999. Refuses to answer

Note to interviewer: *an average amount of time per day spent walking is needed.*

If the respondent cannot answer because the amount of time varies greatly from day to day, ask: What is the total amount of time you spent walking in the last 7 days"?

- ___ Hours per week [WWHRS; Range: 0-112]
 ___ Minutes per week [WWMIN; Range: 0-6720, 9998, 9999]
 9998. Does not know / is not sure
 9999. Refuses to answer

Read the subject: *Now think about the time you spent sitting on weekdays during the last 7 days. Include time spent at work, at home, while studying and during leisure time. This may include time spent sitting at a desk, visiting friends, reading, or sitting and/or lying down (awake) to watch television.*

180- During the last 7 days, how much time did you spend on average sitting on a week day?

- ___ Hours per week [SDHRS; 0-16]
 ___ Minutes per week [SDMIN; Range: 0-960, 998, 999]
 998. Does not know / is not sure
 999. Refuses to answer

Interviewer clarification: *Include time spent lying down (awake) as well as sitting.*

Interviewer note: **An average amount of time per day is needed. If the respondent cannot answer because the amount of time varies day to day, ask: "What was the total amount of time you spent sitting (a) last Wednesday?"**

- ___ Hours last Wednesday [SWHRS; Range 0-16]
 ___ Minutes last Wednesday [SWMIN; Range: 0-960, 998, 999]
 998. Does not know / is not sure
 999. Refuses to answer

Paste identification tag

IDENTIFICATION DATA

CODE: GROUP:

FIRST NAME LAST NAME(S):

BLOOD SAMPLE AND ORAL GLUCOSE TEST TOLERANCE (OGTT)

<p>EXCLUSION CRITERIA FOR BLOOD SAMPLE:</p> <p>181- Have you experienced fever, diarrhea or vomiting in the last week? <input type="checkbox"/> Yes (postpone) <input type="checkbox"/> No <input type="checkbox"/> ns/nc</p> <p>182- When was the last time you had something to eat or drink (other than water)?:</p> <p>183- How many hours spent fasting: hours (if less than 8h, postpone)</p> <p>Exclusion criteria for OGTT:</p> <p>184- Do you have diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> ns/nc</p> <p>185- Do you take insulin? <input type="checkbox"/> Yes (not perform OGTT) <input type="checkbox"/> No <input type="checkbox"/> ns/nc</p> <p>186- Do you take pills for sugar/glycemic control? <input type="checkbox"/> Yes (not perform OGTT) <input type="checkbox"/> No <input type="checkbox"/> ns/nc</p> <p>187- When was the last time you took one?:.....</p>	<p>188- Blood sample date (dd / mm / yy):.....</p> <p>189- Problems and observations:..... </p> <p>190- Capillary basal glycemia: mg/dl 192- Hour:</p> <p>(If higher than 180, repeat and, if confirmed, do not perform OGTT)</p> <p>191- Glycemia post-OGTT (2h): mg/dl 193- Hour:</p> <p>194- Basal venous sample obtained? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>195- Post-OGTT venous sample obtained? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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