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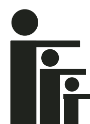
# Physician Survey of Practices on Diet, Physical Activity, and Weight Control

## Questionnaire on Adult Care

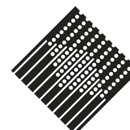
**Conducted by:**

**National Institutes of Health**

**National Institutes of Health**



National Institute of Child Health and Human Development,
**National Institutes of Health**



Office of Behavioral and Social Sciences Research,
**National Institutes of Health**

**Centers for Disease Control and Prevention**

# Physician Survey of Practices on Diet, Physical Activity, and Weight Control

# Questionnaire on Adult Care

## INTRODUCTION

The Physician Survey of Practices on Diet, Physical Activity, and Weight Control — *Adult Questionnaire* is sponsored by the National Cancer Institute in collaboration with the Office of Behavioral and Social Sciences Research, the National Institute of Child Health and Human Development, the National Institute of Diabetes and Digestive and Kidney Diseases, and the Centers for Disease Control and Prevention. It is being sent to a random sample of Family Medicine Physicians, General Internists, Obstetrician/Gynecologists, and Pediatricians. Your name and contact information were provided to us by the American Medical Association.

This survey asks about the evaluation and guidance you provide to your patients about diet, weight, and physical activity.

The information you provide will remain confidential to the fullest extent of the law. Your answers will be aggregated with those of other respondents in reports to NCI and any other parties.

Participation is voluntary, and there are no penalties to you for not responding. However, not responding could seriously affect the accuracy of final results, and your point of view may not be adequately represented in the survey findings.

Please return the completed survey in the enclosed postage-paid envelope. If another envelope is used, please send to:

Westat
Attn: B. Burroughs, RB 3274
1650 Research Blvd.
Rockville, Maryland 20850-3195

Public reporting burden for this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. **An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number.** Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-0583). Do not return the completed form to this address.

# Physician Survey of Practices on Diet, Physical Activity, and Weight Control

**Survey Instructions:**

- When you answer, include ALL the patients you treat in the age range specified.
- Answer the questions regarding your main primary care practice location (i.e., the practice setting where you spend the most hours per week, at which the majority of your patients are seen.)
- Use an X in the box to indicate your answers.
- If your answer is not adequately represented by the available choices, use the box provided in "Other (Please specify):"

☐

## Section A. Patient Populations Treated

**A1. Please indicate the patient population(s) you treat.**

*Check one in each row*

| | Yes | No |
|---|---|---|
| **a.** Do you see infants < 2 years? | 1 ☐ | 0 ☐ |
| **b.** Do you see children 2-11 years? | 1 ☐ | 0 ☐ |
| **c.** Do you see adolescents 12-17 years? | 1 ☐ | 0 ☐ |
| **d.** Do you see adults 18-65 years? | 1 ☐ | 0 ☐ |
| **e.** Do you see older adults 66+ years? | 1 ☐ | 0 ☐ |

**Though you may treat a wide range of patients, the following questions focus on adult populations you treat, age 18 years and older.**

**A2. During routine well-patient physical exams of your adult (18 years and older) patients:**

*Check one in each row*

| | Never | Rarely | Sometimes | Often | Always |
|---|---|---|---|---|---|
| **a.** How often do you assess diet or physical activity? | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ |
| **b.** As a general policy, for your entire adult patient population, how often do you promote: | | | | | |
| Healthy Diet/Nutrition | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ |
| Physical Activity | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ |

**A3. For your adult patients WITHOUT weight-related chronic disease who have an unhealthy diet, are insufficiently active, or are overweight: How often do you...**

| *Check one in each row* | Never | Rarely | Sometimes | Often | Always |
|---|---|---|---|---|---|
| **a.** Provide general counseling for changing diet, physical activity, or weight? | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ |
| **b.** Provide specific guidance on: | | | | | |
| Diet/Nutrition (e.g., "Eat more fruits and vegetables" or "Increase your calcium")? | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ |
| Physical Activity (e.g., "Increase your exercise by walking daily")? | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ |
| Weight Control (e.g., "Lose X lbs by cutting calories and exercising")? | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ |
| **c.** Refer these patients to another health professional or program outside of your practice for further evaluation and/or management? | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ |
| **d.** Systematically track/follow patients over time concerning behaviors or other measures of progress related to diet, physical activity, or weight? | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ |

**A4. For your adult patients WITH weight-related chronic disease who have an unhealthy diet, are insufficiently active, or are overweight: How often do you...**

| *Check one in each row* | Never | Rarely | Sometimes | Often | Always |
|---|---|---|---|---|---|
| **a.** Provide general counseling for changing diet, physical activity, or weight? | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ |
| **b.** Provide specific guidance on: | | | | | |
| Diet/Nutrition (e.g., "Eat more fruits and vegetables" or "Increase your calcium")? | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ |
| Physical Activity (e.g., "Increase your exercise by walking daily")? | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ |
| Weight Control (e.g., "Lose X lbs by cutting calories and exercising")? | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ |
| **c.** Refer these patients to another health professional or program outside of your practice for further evaluation and/or management? | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ |
| **d.** Systematically track/follow patients over time concerning behaviors or other measures of progress related to diet, physical activity, or weight? | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ |

**A5. If you assess diet, HOW do you assess it?**

99 ☐ Not applicable. I do not assess diet. **GO TO A6.**

| *Check one in each row* | Yes | No |
|---|---|---|
| **a.** General questions about food groups (e.g., fruits and vegetables) | 1 ☐ | 0 ☐ |
| **b.** General questions about dietary patterns (e.g., fast food) | 1 ☐ | 0 ☐ |
| **c.** Specific questions about diet components (e.g., calcium, protein) | 1 ☐ | 0 ☐ |
| **d.** Standardized diet questionnaire | 1 ☐ | 0 ☐ |
| **e.** Other (Please specify): ______ | 1 ☐ | 0 ☐ |

**A6. If you assess physical activity, HOW do you assess it?**

99 ☐ Not applicable. I do not assess physical activity. **GO TO A7.**

*Check one in each row*

| | Yes | No |
|---|---|---|
| **a.** General questions about amount of physical activity | 1 ☐ | 0 ☐ |
| **b.** General questions about amount of sedentary activity (e.g., TV watching) | 1 ☐ | 0 ☐ |
| **c.** Specific questions about duration, intensity, and type of physical activity | 1 ☐ | 0 ☐ |
| **d.** Standardized physical activity questionnaire | 1 ☐ | 0 ☐ |
| **e.** Other (Please specify): ______ | 1 ☐ | 0 ☐ |

**A7. How often do you assess the following?**

*Check all that apply*

| | Every well-patient visit | Every visit | Annually | As clinically indicated | Never | Other interval (Please specify) |
|---|---|---|---|---|---|---|
| **a.** Weight measured on a scale | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ | 6 ______ |
| **b.** Weight reported by the patient | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ | 6 ______ |
| **c.** Body mass index (BMI) | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ | 6 ______ |
| **d.** Waist circumference | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ | 6 ______ |
| **e.** Height | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ | 6 ______ |

**A8. How often are the following tests utilized in your practice for overweight/obese adult patients?**

*Check all that apply*

| | Not applicable (do not utilize) | Every 2 years | Annually | Every 6 months | More than twice a year | Other (Please specify) |
|---|---|---|---|---|---|---|
| **a.** Random blood glucose for . . . | | | | | | |
| Patients **with** additional risk factors | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ | 6 ☐ |
| Patients **without** additional risk factors | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ | 6 ☐ |
| **b.** Fasting blood glucose for . . . | | | | | | |
| Patients **with** additional risk factors | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ | 6 ☐ |
| Patients **without** additional risk factors | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ | 6 ☐ |

**A9. Have you ever, or are you currently . . .?**

*Check two for each row*

| | Ever | | Currently | |
|---|---|---|---|---|
| | Yes | No | Yes | No |
| **a.** Prescribing pharmacological treatments for weight control to any of your patients? | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| **b.** Referring any of your patients for surgical treatment for obesity? | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |

**A10. When you treat each of the following conditions, do you address diet/nutrition, physical activity, or weight control?**

*Check all that apply*

| | Do Not Treat This Condition | Diet | Physical Activity | Weight Control |
|---|---|---|---|---|
| **a.** Abnormal body weight/BMI | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| **b.** Abnormal lipid profile | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| **c.** Hypertension | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| **d.** Eating disorders such as anorexia or bulimia | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| **e.** Asthma | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| **f.** Diabetes mellitus (Type II) | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| **g.** Coronary heart disease | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| **h.** Cancer | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| **i.** Arthritis | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| **j.** Sleep apnea | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| **k.** Chronic obstructive lung disease | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| **l.** Back pain/problems/injury | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| **m.** Family history of diabetes mellitus | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| **n.** Family history of heart disease | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| **o.** Family history of cancer | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| **p.** Other (Please specify): ____________ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |

# Section B. Barriers to Patient Assessment, Evaluation, and Management

**B1. Which of the following are the TOP 3 BARRIERS to evaluating and/or managing your patients' diet/nutrition, physical activity, and weight in your practice?**

| | *Check the top 3 barriers* |
|---|---|
| **a.** Not enough time | 0 ☐ 1 |
| **b.** Not part of my role | 0 ☐ 1 |
| **c.** I am not adequately trained in this area | 0 ☐ 1 |
| **d.** Too difficult to evaluate and manage | 0 ☐ 1 |
| **e.** Inadequate reimbursement | 0 ☐ 1 |
| **f.** Lack of adequate referral services for diet, physical activity, and weight | 0 ☐ 1 |
| **g.** Patients are not interested in improving their diet, physical activity, or weight levels | 0 ☐ 1 |
| **h.** Fear of offending the patient | 0 ☐ 1 |
| **i.** Too difficult for patients to change their behavior | 0 ☐ 1 |
| **j.** Lack of effective tools and information to give to patients | 0 ☐ 1 |
| **k.** Lack of effective treatment options | 0 ☐ 1 |
| **l.** Other (Please specify): ____________ | 0 ☐ 1 |

**B2. Relative to your current practice, what are the TOP 3 IMPROVEMENTS that could assist you in reducing patients' health issues related to diet, physical activity, and weight?**

| | *Check the top 3 improvements* |
|---|---|
| **a.** Ways to more easily **identify** problems with diet, physical activity, and weight | 0 ☐ 1 |
| **b.** Easy-to-understand patient management **guidelines** | 0 ☐ 1 |
| **c.** Better **reimbursement** for counseling | 0 ☐ 1 |
| **d.** Better **tools to communicate** diet, physical activity, or weight problems to patient or family | 0 ☐ 1 |
| **e.** Better **counseling tools** to guide patients toward lifestyle modification | 0 ☐ 1 |
| **f.** More **training** for your **staff** in evaluating and managing patient diet, physical activity, and weight | 0 ☐ 1 |
| **g.** More **training** for **you** in evaluating and managing patient diet, physical activity, and weight | 0 ☐ 1 |
| **h.** Better **information systems** to **document and track goals** in the medical record | 0 ☐ 1 |
| **i.** Better **information systems** to identify appropriate **referral services** | 0 ☐ 1 |
| **j.** Better **mechanism to connect** patient to specific referral services | 0 ☐ 1 |
| **k.** Other (Please specify): ________ | 0 ☐ 1 |

## PERSONAL BELIEFS

**B3. Please indicate how strongly you agree with each of the following statements.**

*Check one in each row*

| | Strongly agree | Agree somewhat | Neither agree nor disagree | Disagree somewhat | Strongly disagree |
|---|---|---|---|---|---|
| **a.** Physicians have a responsibility to promote the following with their patients: | | | | | |
| eat a healthy diet. | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ |
| be adequately physically active. | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ |
| maintain a healthy weight or lose weight. | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ |
| **b.** Patients are more likely to adopt healthier lifestyles if physicians counsel them to do so. | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ |
| **c.** There are effective strategies and/or tools to help patients: | | | | | |
| eat a healthy diet. | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ |
| be adequately physically active. | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ |
| maintain a healthy weight or lose weight. | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ |
| **d.** I am confident in my ability to counsel my patients to: | | | | | |
| eat a healthy diet. | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ |
| be adequately physically active. | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ |
| maintain a healthy weight or lose weight. | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ |
| **e.** I am effective at helping my patients: | | | | | |
| eat a healthy diet. | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ |
| be adequately physically active. | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ |
| maintain a healthy weight or lose weight. | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ |
| **f.** To effectively encourage patient adherence to a healthy lifestyle, a physician must adhere to one him/herself. | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ |
| **g.** Specifically, a physician will be able to provide more credible and effective counseling if he/she: | | | | | |
| eats a healthy diet. | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ |
| is adequately physically active. | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ |
| maintains a healthy weight or loses weight. | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ |

**B4. According to current guidelines, at what BMI level are adult patients (18 years or older) considered to be . . .**

*Check one in each row*

| | ≥ 20 kg/m² | ≥ 25 kg/m² | ≥ 30 kg/m² | ≥ 35 kg/m² | Don't Know |
|---|---|---|---|---|---|
| **a.** Overweight? | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 8 ☐ |
| **b.** Obese? | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 8 ☐ |

**B5. According to current guidelines, in what BMI percentile range are children or adolescents (2-17 years) considered to have healthy weight?**

*Check one box*

1 ☐ 5th–65th percentile
2 ☐ 5th–75th percentile
3 ☐ 5th–85th percentile
4 ☐ 5th–95th percentile
5 ☐ Other (Please specify): ________
8 ☐ Don't Know

**B6. According to current guidelines, for adults, 18 and older, how much moderate physical activity is recommended (on most days of the week) for general health and prevention of chronic diseases?**

*Check one box*

1 ☐ 20 minutes
2 ☐ 30 minutes
3 ☐ 40 minutes
4 ☐ 60 minutes
5 ☐ 90 minutes
6 ☐ Other (Please specify): ________
8 ☐ Don't Know

**B7. According to current guidelines, for adults, 18 and older, how many servings of fruits and vegetables should a person have in a day?**

*Check one box*

1 ☐ 3 servings
2 ☐ 5 servings
3 ☐ 7 servings
4 ☐ It depends on daily calorie intake
5 ☐ Other (Please specify): ________
8 ☐ Don't Know

## Section C. Your Personal Health Status/Health Behaviors

**C1. In general, would you say your health is:**

*Check one*

| | Excellent | Very Good | Good | Fair | Poor |
|---|---|---|---|---|---|
| | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ |

**C2. These questions are about the foods you ate or drank during the PAST MONTH, that is, the past 30 days. Please include meals and snacks eaten at home, at work or school, in restaurants, and any place else.**

*Check one in each row*

| | Never | 1-3 times last month | 1-2 times per week | 3-4 times per week | 5-6 times per week | 1 time per day | 2 times per day | 3 or more times per day | 4 or more times per day | 5 or more times per day |
|---|---|---|---|---|---|---|---|---|---|---|
| **a.** How often did you drink 100% FRUIT Juice, such as orange, mango, apple, or grape juices? Do NOT include fruit drinks. | 00 ☐ | 01 ☐ | 02 ☐ | 03 ☐ | 04 ☐ | 05 ☐ | 06 ☐ | 07 ☐ | 08 ☐ | 09 ☐ |
| **b.** How often did you eat FRUIT? INCLUDE fresh, frozen, or canned fruit. Do NOT include juices. | 00 ☐ | 01 ☐ | 02 ☐ | 03 ☐ | 04 ☐ | 05 ☐ | 06 ☐ | 07 ☐ | 08 ☐ | 09 ☐ |
| **c.** How often did you eat FRENCH FRIES or home fries or hash brown potatoes? | 00 ☐ | 01 ☐ | 02 ☐ | 03 ☐ | 04 ☐ | 05 ☐ | 06 ☐ | 07 ☐ | 08 ☐ | 09 ☐ |
| **d.** How often did you eat other POTATOES? INCLUDE baked, boiled, mashed, or potato salad. | 00 ☐ | 01 ☐ | 02 ☐ | 03 ☐ | 04 ☐ | 05 ☐ | 06 ☐ | 07 ☐ | 08 ☐ | 09 ☐ |
| **e.** Not including potatoes (and not counting rice), how often did you eat OTHER VEGETABLES? | 00 ☐ | 01 ☐ | 02 ☐ | 03 ☐ | 04 ☐ | 05 ☐ | 06 ☐ | 07 ☐ | 08 ☐ | 09 ☐ |

## PHYSICAL ACTIVITY

**C3. Moderate physical activities make you breathe somewhat harder than normal. During the last 7 days, did you do any moderate physical activities for at least 10 minutes? Think about activities such as bicycling, swimming, brisk walking, dancing, or gardening.**

0 ☐ No → **Go to C4**

1 ☐ Yes

**a.** On how many of the past 7 days did you do moderate physical activities?

☐ Days

**b.** In the past 7 days, on a typical day in which you did moderate physical activities, how much time did you spend doing them?

☐☐☐ Minutes per day

**C4. Vigorous activities make you breathe much harder than normal. Now think about vigorous activities you did that take hard physical effort, such as aerobics, running, soccer, fast bicycling, or fast swimming. During the last 7 days, did you do any vigorous physical activities in your free time for at least 10 minutes?**

0 ☐ No → **Go to C5**

1 ☐ Yes

**a.** On how many of the past 7 days did you do vigorous physical activities?

☐ Days

**b.** In the past 7 days, on a typical day in which you did vigorous physical activities, how much time did you spend doing them?

☐☐☐ Minutes per day

**C5. Now think about activities specifically designed to STRENGTHEN your muscles, such as lifting weights or other strength-building exercises. Include all such activities even if you have included them before. During the last 7 days, did you do activities to strengthen your muscles?**

- 0 ☐ No ⟶ **Go to C6**
- 1 ☐ Yes

## HEIGHT AND WEIGHT STATUS

**C6. How tall are you without shoes?**

☐ Feet ☐☐ Inches

**IF YOU ARE FEMALE AND CURRENTLY PREGNANT, GO TO C7a.**
**OTHERWISE GO TO C7.**

**C7. How much do you weigh without shoes?**

☐☐☐ Pounds

**C7a. If you are currently pregnant, how much did you weigh before your pregnancy?**

☐☐☐ Pounds

**C8. Are you currently trying to:**

*Check one*

- 1 ☐ Lose weight
- 2 ☐ Gain weight
- 3 ☐ Maintain weight
- 4 ☐ Not trying to make a change

## PHYSICIAN CHARACTERISTICS

**C9. When were you born?**

| 1 | 9 | | |
|---|---|---|---|

Year

**C10. Are you . . .**

*Check one*

0 ☐ Female    1 ☐ Male

**C11. Do you consider yourself to be Hispanic or Latino/a?**

*Check one*

1 ☐ Yes    0 ☐ No

**C12. What do you consider to be your race?**

*Check all that apply*

- 0 ☐ 1 American Indian or Alaska Native
- 0 ☐ 1 Asian
- 0 ☐ 1 Black or African-American
- 0 ☐ 1 Native Hawaiian or Other Pacific Islander
- 0 ☐ 1 White

**C13. During a typical month, approximately what percent of your professional time do you spend in the following activities?**

| | *Percent of professional time* |
|---|---|
| **a.** Providing Primary Care | ☐☐☐ % |
| **b.** Providing Subspecialty Care (Please specify): ________ | ☐☐☐ % |
| **c.** Research | ☐☐☐ % |
| **d.** Teaching | ☐☐☐ % |
| **e.** Administration | ☐☐☐ % |
| **f.** Other (Please specify): ________ | ☐☐☐ % |
| **Total** | **1 0 0** % |

## PRACTICE CHARACTERISTICS

**C14. Which of the following categories best describes your main primary care practice location? Are you a . . .**

*Check all that apply*

| | |
|---|---|
| **a.** Full- or part-owner of a physician practice | 0 ☐ 1 |
| **b.** Employee of a physician-owned practice | 0 ☐ 1 |
| **c.** Employee of a large medical group or health care system | 0 ☐ 1 |
| **d.** Employee of a staff or group model HMO | 0 ☐ 1 |
| **e.** Employee of a university hospital or clinic | 0 ☐ 1 |
| **f.** Employee of a hospital or clinic not associated with a university (including community health clinics) | 0 ☐ 1 |
| **g.** Other (Please specify): ______ | 0 ☐ 1 |

**C15. Please estimate the number of patient visits that you have in a TYPICAL WEEK, EXCLUDING patient visits while on-call (on-call is defined as time outside of regularly scheduled clinical activity):**

☐☐☐ Number of Patient Visits

998 ☐ Don't Know

**C16. Approximately what percentage of the patients you treat is female?**

☐☐☐ %

998 ☐ Don't Know

**C17. Approximately what percentage of the patients you treat is Hispanic or Latino?**
(Please give your best estimate)

*Check one*

| | |
|---|---|
| **a.** 0–5% | 1 ☐ |
| **b.** 6–25% | 2 ☐ |
| **c.** 26–50% | 3 ☐ |
| **d.** 51–75% | 4 ☐ |
| **e.** 76–100% | 5 ☐ |
| **f.** Don't Know | 8 ☐ |

**C18. Approximately what percentage of the patients you treat is . . .**
(Please give your best estimate)

| | *Percent of patients* |
|---|---|
| **a.** White | ☐☐☐ % |
| **b.** Black or African-American | ☐☐☐ % |
| **c.** Asian | ☐☐☐ % |
| **d.** Native Hawaiian or Other Pacific Islander | ☐☐☐ % |
| **e.** American Indian or Alaska Native | ☐☐☐ % |
| **Total** | **1 0 0** % |

**C19. Within a practice, there may be multiple clinical sites at which medical care is delivered.**

*Check one*

| | Yes | No |
|---|---|---|
| Does this practice have more than one clinical site? | 1 ☐ | 0 ☐ |

**C20. About how many physicians, nurse practitioners, and physician assistants provide care in all of the clinical sites within this practice?**

*Check one*

| | |
|---|---|
| **a.** 1 | 1 ☐ |
| **b.** 2–5 | 2 ☐ |
| **c.** 6–20 | 3 ☐ |
| **d.** More than 20 and fewer than 100 | 4 ☐ |
| **e.** More than 100 | 5 ☐ |
| **f.** Don't Know | 8 ☐ |

**C21. If this survey were available on the Internet as a web-based questionnaire, would you prefer to fill it out online, or is a paper and pencil survey more convenient for you?**

*Check one*

1 ☐ I prefer paper and pencil

2 ☐ I prefer a web-based questionnaire

3 ☐ I have no preference

4 ☐ Other (Please specify): ______

**C22. We would like to obtain additional information about aspects of the practice that support disease prevention activities. However, we know your time is limited, so we'd like to send your office administrator a short questionnaire of about 20 questions related to the structure of your practice and the roles of different staff that work there. Please give us the name of your office administrator, or indicate whether it would be better for us to send the brief questionnaire to you.**

Check one: ☐ Dr. ☐ Mr. ☐ Ms. ☐ Mrs.

First Name: ☐☐☐☐☐☐☐

Last Name: ☐☐☐☐☐☐☐☐☐☐

1 ☐ The office administrator in my practice is less familiar with the clinical roles of my staff; I am the best person to answer questions about my practice.

**If you have any comments about the questionnaire, individual questions, or the burden, please make them here. We appreciate your participation and feedback.**

**Thank you very much.**
**We greatly appreciate your participation.**

**Please return your completed survey in the enclosed postage-paid envelope.**

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