

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

Questionnaire on Child/Adolescent Care

Conducted by:



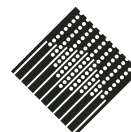
National Institutes of Health



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

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INTRODUCTION

The Physician Survey of Practices on Diet, Physical Activity, and Weight Control – *Child/Adolescent Questionnaire* is sponsored by the National Cancer Institute in collaboration with the Office of Behavioral and Social Science 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

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 <input type="checkbox"/>	0 <input type="checkbox"/>
b. Do you see children 2-11 years?	1 <input type="checkbox"/>	0 <input type="checkbox"/>
c. Do you see adolescents 12-17 years?	1 <input type="checkbox"/>	0 <input type="checkbox"/>
d. Do you see adults 18-65 years?	1 <input type="checkbox"/>	0 <input type="checkbox"/>
e. Do you see older adults 66+ years?	1 <input type="checkbox"/>	0 <input type="checkbox"/>

Though you may treat a wide range of patients, this survey focuses on your practices involving your child/adolescent patients (ages 2-17).

The next questions are about practices involving child/adolescent patients (ages 2-17).

A2. During routine well-patient physical exams of your child/adolescent patients (ages 2-17):

Check one in each row

	Never	Rarely	Sometimes	Often	Always
a. How often do you <u>assess</u> diet or physical activity?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
b. As a general policy, for your entire child/adolescent patient population, how often do you promote:					
Healthy Diet/Nutrition	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Physical Activity	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

A3. For your child/adolescent patients who have an unhealthy diet, are insufficiently active, are overweight, or are at risk for weight-related chronic disease:

Check one in each row

	Never	Rarely	Sometimes	Often	Always
a. How often do you provide <u>general counseling</u> for changing diet, physical activity, or weight?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
b. How often do you provide <u>specific guidance</u> on:					
Diet/Nutrition (e.g., “Eat more fruits and vegetables” or “Increase your calcium”)?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Physical Activity (e.g., “Increase your exercise by walking daily”)?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Weight Control (e.g., “Lose <u>X</u> lbs by cutting calories and exercising”)?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
c. How often do you <u>refer</u> these patients to another health professional or program outside of your practice for further evaluation and/or management?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
d. How often do you systematically <u>track/follow</u> patients over time concerning behaviors or other measures of progress related to diet, physical activity, or weight?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

A4. When you assess diet in patients 2-17 years, HOW do you assess it?

99 Not applicable. I do not assess diet. **GOTO A5.**

Check one in each row

	<i>Yes</i>	<i>No</i>
a. <u>General</u> questions about food groups (e.g., fruits and vegetables)	1 <input type="checkbox"/>	0 <input type="checkbox"/>
b. <u>General</u> questions about dietary patterns (e.g., fast food)	1 <input type="checkbox"/>	0 <input type="checkbox"/>
c. <u>Specific</u> questions about diet components (e.g., calcium, protein)	1 <input type="checkbox"/>	0 <input type="checkbox"/>
d. Standardized diet questionnaire	1 <input type="checkbox"/>	0 <input type="checkbox"/>
e. Other (Please specify): <input style="width: 300px; height: 20px;" type="text"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>

A5. When you assess physical activity in patients 2-17 years, HOW do you assess it?

99 Not applicable. I do not assess physical activity. **GOTO A6.**

Check one in each row

	<i>Yes</i>	<i>No</i>
a. <u>General</u> questions about amount of physical activity	1 <input type="checkbox"/>	0 <input type="checkbox"/>
b. <u>General</u> questions about amount of sedentary activity (e.g., TV watching)	1 <input type="checkbox"/>	0 <input type="checkbox"/>
c. <u>Specific</u> questions about duration, intensity, and type of physical activity	1 <input type="checkbox"/>	0 <input type="checkbox"/>
d. Standardized physical activity questionnaire	1 <input type="checkbox"/>	0 <input type="checkbox"/>
e. Other (Please specify): <input style="width: 300px; height: 20px;" type="text"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>

A6. How often do you assess the following in children or adolescents (ages 2-17)?

Check all that apply

	Every well-patient visit	Every visit	Annually	As clinically indicated	Never	Other interval (Please specify)
a. Weight measured in office	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="text"/>
b. Height measured in office	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="text"/>
c. Body mass Index (BMI)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="text"/>
d. Waist circumference or waist-to-hip ratio	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="text"/>
e. Weight-for-age growth charts	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="text"/>
f. Stature-for-age growth charts	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="text"/>
g. BMI-for-age growth chart	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="text"/>

A7. How often do you assess or review the following in infants (ages <2)?

Check all that apply

	Every well-patient visit	Every visit	Annually	As clinically indicated	Never	Other interval (Please specify)
a. Weight measured in office	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="text"/>
b. Length measured in office	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="text"/>
c. Growth chart	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="text"/>
d. Weight-for-length growth charts	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="text"/>
e. Weight-for-age growth charts	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="text"/>
f. Length-for-age growth chart	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="text"/>

A8. For your OVERWEIGHT/OBESE child/adolescent patients (ages 2-17), at what age do you begin performing the following tests?

If you DO NOT perform these tests, please check "N/A"

Check one in each row

	N/A	Age in Years
a. <u>Random</u> blood glucose testing for . . .		
Patients with risk factors or family history	0 <input type="checkbox"/>	<input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/>
Patients without risk factors or family history	0 <input type="checkbox"/>	<input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/>
b. <u>Fasting</u> blood glucose testing for . . .		
Patients with risk factors or family history	0 <input type="checkbox"/>	<input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/>
Patients without risk factors or family history	0 <input type="checkbox"/>	<input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/>

A9. How often are the following tests utilized in your practice for OVERWEIGHT/OBESE children/adolescent patients (ages 2-17)?

If you DO NOT perform these tests, please check "N/A"

Check all that apply

	N/A	Every 2 years	Annually	Every 6 months	More than twice a year	Other (Please specify)
a. <u>Random</u> blood glucose for . . .						
Patients with additional risk factors	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input style="width: 150px; height: 20px;" type="text"/>
Patients without additional risk factors	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input style="width: 150px; height: 20px;" type="text"/>
b. <u>Fasting</u> blood glucose for . . .						
Patients with additional risk factors	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input style="width: 150px; height: 20px;" type="text"/>
Patients without additional risk factors	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input style="width: 150px; height: 20px;" type="text"/>

A10. When you treat each of the following conditions for your child/adolescent patients (ages 2-17), 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	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
b. Elevated blood pressure	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
c. Abnormal lipid profile	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
d. Eating disorders such as anorexia or bulimia	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
e. Asthma	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
f. Diabetes mellitus (Type II)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
g. Family history of diabetes mellitus	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
h. Family history of heart disease	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
i. Family history of cancer	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
j. Other (Please specify): <input style="width: 250px; height: 20px;" type="text"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

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 <input type="checkbox"/> 1
b. Not part of my role	0 <input type="checkbox"/> 1
c. I am not adequately trained in this area	0 <input type="checkbox"/> 1
d. Too difficult to evaluate and manage	0 <input type="checkbox"/> 1
e. Inadequate reimbursement	0 <input type="checkbox"/> 1
f. Lack of adequate referral services for diet, physical activity, and weight	0 <input type="checkbox"/> 1
g. Patients are not interested in improving their diet, physical activity, or weight levels	0 <input type="checkbox"/> 1
h. Fear of offending the patient	0 <input type="checkbox"/> 1
i. Too difficult for patients to change their behavior	0 <input type="checkbox"/> 1
j. Lack of effective tools and information to give to patients	0 <input type="checkbox"/> 1
k. Lack of effective treatment options	0 <input type="checkbox"/> 1
l. Other (Please specify): <input style="width: 500px; height: 20px;" type="text"/>	0 <input type="checkbox"/> 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 <input type="checkbox"/> 1
b. Easy-to-understand patient management guidelines	0 <input type="checkbox"/> 1
c. Better reimbursement for counseling	0 <input type="checkbox"/> 1
d. Better tools to communicate diet, physical activity, or weight problems to patient or family	0 <input type="checkbox"/> 1
e. Better counseling tools to guide patients toward lifestyle modification	0 <input type="checkbox"/> 1
f. More training for your staff in evaluating and managing patient diet, physical activity, and weight	0 <input type="checkbox"/> 1
g. More training for you in evaluating and managing patient diet, physical activity, and weight	0 <input type="checkbox"/> 1
h. Better information systems to document and track goals in the medical record	0 <input type="checkbox"/> 1
i. Better information systems to identify appropriate referral services	0 <input type="checkbox"/> 1
j. Better mechanism to connect patient to specific referral services	0 <input type="checkbox"/> 1
k. Other (Please specify): <input type="text"/>	0 <input type="checkbox"/> 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

	1	2	3	4	5
a. Physicians have a responsibility to promote the following with their patients:					
eat a healthy diet.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
be adequately physically active.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
maintain a healthy weight or lose weight.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
b. Patients are more likely to adopt healthier lifestyles if physicians counsel them to do so.					
	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
c. There are effective strategies and/or tools to help patients:					
eat a healthy diet.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
be adequately physically active.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
maintain a healthy weight or lose weight.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
d. I am confident in my ability to counsel my patients to:					
eat a healthy diet.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
be adequately physically active.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
maintain a healthy weight or lose weight.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
e. I am effective at helping my patients:					
eat a healthy diet.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
be adequately physically active.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
maintain a healthy weight or lose weight.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
f. To effectively encourage patient adherence to a healthy lifestyle, a physician must adhere to one him/herself.					
	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
g. Specifically, a physician will be able to provide more credible and effective counseling if he/she:					
eats a healthy diet.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
is adequately physically active.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
maintains a healthy weight or loses weight.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

B4. According to current guidelines, at what BMI level are child/adolescent patients (ages 2-17) considered to be . . .

Check one in each row

	$\geq 20 \text{ kg/m}^2$	$\geq 25 \text{ kg/m}^2$	$\geq 30 \text{ kg/m}^2$	$\geq 35 \text{ kg/m}^2$	Don't Know
a. Overweight?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	8 <input type="checkbox"/>
b. Obese?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	8 <input type="checkbox"/>

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 children/adolescents, (2-17 years), 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 children/adolescents, ages 2-17, 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 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

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 <input type="checkbox"/>	01 <input type="checkbox"/>	02 <input type="checkbox"/>	03 <input type="checkbox"/>	04 <input type="checkbox"/>	05 <input type="checkbox"/>	06 <input type="checkbox"/>	07 <input type="checkbox"/>	08 <input type="checkbox"/>	09 <input type="checkbox"/>
b. How often did you eat FRUIT? INCLUDE fresh, frozen, or canned fruit. Do NOT include juices.	00 <input type="checkbox"/>	01 <input type="checkbox"/>	02 <input type="checkbox"/>	03 <input type="checkbox"/>	04 <input type="checkbox"/>	05 <input type="checkbox"/>	06 <input type="checkbox"/>	07 <input type="checkbox"/>	08 <input type="checkbox"/>	09 <input type="checkbox"/>
c. How often did you eat FRENCH FRIES or home fries or hash brown potatoes?	00 <input type="checkbox"/>	01 <input type="checkbox"/>	02 <input type="checkbox"/>	03 <input type="checkbox"/>	04 <input type="checkbox"/>	05 <input type="checkbox"/>	06 <input type="checkbox"/>	07 <input type="checkbox"/>	08 <input type="checkbox"/>	09 <input type="checkbox"/>
d. How often did you eat other POTATOES? INCLUDE baked, boiled, mashed, or potato salad.	00 <input type="checkbox"/>	01 <input type="checkbox"/>	02 <input type="checkbox"/>	03 <input type="checkbox"/>	04 <input type="checkbox"/>	05 <input type="checkbox"/>	06 <input type="checkbox"/>	07 <input type="checkbox"/>	08 <input type="checkbox"/>	09 <input type="checkbox"/>
e. Not including potatoes (and not counting rice), how often did you eat OTHER VEGETABLES?	00 <input type="checkbox"/>	01 <input type="checkbox"/>	02 <input type="checkbox"/>	03 <input type="checkbox"/>	04 <input type="checkbox"/>	05 <input type="checkbox"/>	06 <input type="checkbox"/>	07 <input type="checkbox"/>	08 <input type="checkbox"/>	09 <input type="checkbox"/>

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	<input type="text"/>	<input type="text"/>	<input type="text"/>	%
b. Providing Subspecialty Care (Please specify): <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	%
c. Research	<input type="text"/>	<input type="text"/>	<input type="text"/>	%
d. Teaching	<input type="text"/>	<input type="text"/>	<input type="text"/>	%
e. Administration	<input type="text"/>	<input type="text"/>	<input type="text"/>	%
f. Other (Please specify): <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	%
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 <input type="checkbox"/> 1
b. Employee of a physician-owned practice	0 <input type="checkbox"/> 1
c. Employee of a large medical group or health care system	0 <input type="checkbox"/> 1
d. Employee of a staff or group model HMO	0 <input type="checkbox"/> 1
e. Employee of a university hospital or clinic	0 <input type="checkbox"/> 1
f. Employee of a hospital or clinic not associated with a university (including community health clinics)	0 <input type="checkbox"/> 1
g. Other (Please specify): <input type="text"/>	0 <input type="checkbox"/> 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):

<input type="text"/>	<input type="text"/>	<input type="text"/>	Number of Patient Visits
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998 Don't Know

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

<input type="text"/>	<input type="text"/>	<input type="text"/>	%
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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 <input type="checkbox"/>
b. 6–25%	2 <input type="checkbox"/>
c. 26–50%	3 <input type="checkbox"/>
d. 51–75%	4 <input type="checkbox"/>
e. 76–100%	5 <input type="checkbox"/>
f. Don't Know	8 <input type="checkbox"/>

C18. Approximately what percentage of the patients you treat is . . .

(Please give your best estimate)

Percent of patients

a. White	<input type="text"/> <input type="text"/> <input type="text"/> %
b. Black or African-American	<input type="text"/> <input type="text"/> <input type="text"/> %
c. Asian	<input type="text"/> <input type="text"/> <input type="text"/> %
d. Native Hawaiian or Other Pacific Islander	<input type="text"/> <input type="text"/> <input type="text"/> %
e. American Indian or Alaska Native	<input type="text"/> <input type="text"/> <input type="text"/> %
Total	1 0 0 %

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

Check one

Does this practice have more than one clinical site?	Yes	No
	1 <input type="checkbox"/>	0 <input type="checkbox"/>

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 <input type="checkbox"/>
b. 2–5	2 <input type="checkbox"/>
c. 6–20	3 <input type="checkbox"/>
d. More than 20 and fewer than 100	4 <input type="checkbox"/>
e. More than 100	5 <input type="checkbox"/>
f. Don't Know	8 <input type="checkbox"/>

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:

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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