PLEASE USE PENCIL!

1. Your current weight?

POUNDS

0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6
	7	7
	8	8
	9	9

2. Is this your correct date of birth?

◯ Yes
◯ No → If No, please write correct date. MONTH / DAY / YEAR

3. Do you currently smoke cigarettes?

◯ Yes → **How many per day?** ◯ 1–4 ◯ 5–14 ◯ 15–24 ◯ 25–34 ◯ 35–44 ◯ 45+
◯ No

4. Have you had your uterus removed (with or without removal of Fallopian tubes)?

◯ No ◯ Yes, uterus and Fallopian tubes ◯ Yes, uterus only } **Date of surgery:** ◯ Before June 1, 2021 ◯ After June 1, 2021

5. Have you ever had either of your ovaries surgically removed?

◯ No ◯ Yes → **a) How many ovaries do you have remaining?** ◯ None ◯ One

6. Since June 2021, have you used prescription female hormones? (Not including oral contraceptives.)

◯ Yes → **a) How many months did you use hormones since June 2021?**
◯ 1–4 months ◯ 5–9 ◯ 10–14 ◯ 15–19 ◯ 20–25 ◯ 26–30 ◯ 31–35 ◯ 36+ months

◯ No

b) Are you *currently* using them (within the last month)? ◯ Yes ◯ No **If No, skip to question 7.**

c) Mark the type(s) of hormones you are *CURRENTLY* using:

Combined: ◯ Prempro ◯ Combipatch ◯ FemHRT ◯ Climara Pro ◯ Bijuva ◯ Duavee

Estrogen: ◯ Oral Premarin or conjugated estrogen ◯ Oral Estrace or oral estradiol ◯ Patch estrogen ◯ Estrogen gels, creams, sprays on skin ◯ Estrogen + testosterone ◯ Other estrogen (specify below)

Vaginal Estrogen: ◯ Estring ◯ Femring ◯ Other vaginal estrogen

Progesterone/ Progestin: ◯ Oral Provera/Cycrin/MPA ◯ Oral Micronized progesterone or oral Prometrium ◯ Vaginal progesterone ◯ Other progesterone (specify type)

Other hormones: ◯ Testosterone ◯ Compounded bioidentical Estrogen ◯ Prasterone (Intrarosa) ◯ Compounded bioidentical Progesterone ◯ Ospemifene (Osphena) ◯ Other (specify type)

7. In the past two years have you had . . .
(If yes, mark all that apply)

	No	Yes, for Screening	Yes, for Symptoms
A physical exam?	N	Y	Y
Exam by eye doctor?	N	Y	Y
Mammogram?	N	Y	Y
Fasting blood sugar?	N	Y	Y

Upper endoscopy? Ⓝ No Ⓨ Yes

Cologuard (fecal DNA)? Ⓝ No Ⓨ Yes

Fecal occult blood or immunochemical (FIT) test? Ⓝ No Ⓨ Yes

Colonoscopy or Sigmoidoscopy? Ⓝ No Ⓨ Yes → **Initial reason(s) you had this Colonoscopy or Sigmoidoscopy?**
◯ Visible blood ◯ Diarrhea/constipation
◯ Fecal blood (e.g., FIT) ◯ Fecal or stool DNA testing (e.g., Cologuard)
◯ Barium enema ◯ Family history of colon cancer
◯ Abdominal pain ◯ Follow-up of (virtual) CT colonoscopy
◯ Prior polyps or prior cancer ◯ Asymptomatic or routine screening

For Office Use

H	0	1	2	3	4	5	6	7	8	9
	0	1	2	3	4	5	6	7	8	9
	0	1	2	3	4	5	6	7	8	9
C	0	1	2	3	4	5	6	7	8	9
	0	1	2	3	4	5	6	7	8	9
	0	1	2	3	4	5	6	7	8	9

8. In the PAST 12 MONTHS, have you used any cannabis product for medicinal or recreational purposes?

◯ Yes, containing THC → **a) In the PAST 12 MONTHS, how often did you use any cannabis product?**
◯ Yes, containing CBD only → ◯ Monthly or less ◯ Weekly ◯ Daily ◯ More than once per day
◯ No

b) In the PAST 12 MONTHS, what was the usual way you used cannabis?
◯ Smoking/vaping ◯ Edibles ◯ Other

9. How often do you use a laxative (such as softeners, bulking agents, or suppositories)?

◯ Never ◯ <Once/month ◯ 1–3 times/month ◯ Once/week ◯ 2–3 times/wk ◯ 4–5 times/wk ◯ Daily ◯ 2+ times/day

10. How frequently do you have a bowel movement?

◯ More than twice a day ◯ Twice a day ◯ Daily ◯ Every other day ◯ Every 3–4 days ◯ Every 5 days or less often

11. Since June 2021, have you had any of these clinician-diagnosed illnesses?

MARK HERE FOR "YES," LEAVE BLANK FOR "NO"

#	Illness	Yes	YEAR OF DIAGNOSIS: BEFORE JUNE 1 2021	JUNE '21 TO MAY 2023	AFTER JUNE 1 2023
1	Fibrocystic/other benign breast disease	Y			
a	Confirmed by biopsy? (N) No (Y) Yes				
2	Breast cancer	Y			
3	Cancer of the ovary	Y			
4	Leukemia or Lymphoma	Y			
5	Melanoma	Y			
6	Basal cell skin cancer	Y			
7	Squamous cell skin cancer	Y			
8	Cancer of the colon or rectum	Y			
9	Other cancer	Y			
	Specify site of other cancer: (e.g., uterus, pancreas, lung, etc.)				
10	Diabetes mellitus	Y			
11	Elevated cholesterol	Y			
12	High blood pressure	Y			
13	Myocardial infarction	Y			
a	Hospitalized for MI? (N) No (Y) Yes				
14	Angina pectoris	Y			
a	Confirmed by angiogram? (N) No (Y) Yes				
15	Coronary bypass, angioplasty, or stent	Y			
16	Heart failure	Y			
17	Stroke (CVA)	Y			
18	TIA (Transient ischemic attack)	Y			
19	Carotid surgery (Endarterectomy)	Y			
20	Pulmonary embolus	Y			
21	Atrial fibrillation	Y			
22	Osteoporosis	Y			
23	Osteoarthritis	Y			
24	Asthma, clinician diagnosed	Y			
25	COPD/Emphysema/ Chronic bronchitis	Y			

Since June 2021, have you had any of these clinician-diagnosed illnesses?

MARK HERE FOR "YES," LEAVE BLANK FOR "NO"

#	Illness	Yes	YEAR OF DIAGNOSIS: BEFORE JUNE 1 2021	JUNE '21 TO MAY 2023	AFTER JUNE 1 2023
26	Hip fracture	Y			
27	Hip replacement	Y			
28	Wrist or Colles fracture	Y			
29	Vertebral (spine) fracture	Y			
30	Knee replacement	Y			
31	Glaucoma	Y			
32	Cataract extraction	Y			
33	Endometriosis (confirmed by laparoscopy)	Y			
34	Kidney stones	Y			
35	Cholecystectomy	Y			
36	Depression, clinician diagnosed	Y			
37	Alzheimer's or other type of dementia	Y			
38	Parkinson's disease	Y			
39	ALS (Amyotrophic Lat. Sclerosis)	Y			
40	Multiple Sclerosis	Y			
41	Rheumatoid Arthritis or Systemic Lupus (SLE)	Y			
42	Sleep Apnea	Y			
43	Chronic viral hepatitis (B or C)	Y			
44	Gastric/duodenal ulcer	Y			
45	Barrett's esophagus	Y			
46	Celiac disease	Y			
47	Crohn's/ Ulcerative colitis/ Microscopic colitis	Y			
48	Other major illness or surgery since June 2021	Y			

Please specify: Date:

(e.g., deep vein thrombosis, GERD, etc.)

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0 1 2 3 4 5 6 7 8 9

0 1 2 3 4 5 6 7 8 9 0 1 2 3 4 5 6 7 8 9

12. Have you *ever* had any of these clinician-diagnosed illnesses?

MARK HERE FOR "YES," LEAVE BLANK FOR "NO"

		YEAR OF FIRST DIAGNOSIS				
		BEFORE 2006	2006–2012	2013–2018	2019–2020	2021 +
Colon or rectal polyp (benign)	Ⓨ	◯	◯	◯	◯	◯
Fatty liver	Ⓨ	◯	◯	◯	◯	◯
Confirmed by liver biopsy? ◯ No ◯ Yes						
Liver cirrhosis	Ⓨ	◯	◯	◯	◯	◯
Pre-diabetes (Glucose intolerance)	Ⓨ	◯	◯	◯	◯	◯
Gout	Ⓨ	◯	◯	◯	◯	◯
Pseudogout	Ⓨ	◯	◯	◯	◯	◯
Shingles	Ⓨ	◯	◯	◯	◯	◯
Vaccine for shingles	Ⓨ	◯	◯	◯	◯	◯
Polymyalgia rheumatica	Ⓨ	◯	◯	◯	◯	◯
Temporal arteritis (Giant cell arteritis)	Ⓨ	◯	◯	◯	◯	◯

13. In the past 2 years, have you had migraine headaches?

◯ Yes → **Did you sometimes have an aura?** ◯ No ◯ Yes

◯ No

On average, on *how many days per month* do you get migraine headaches? ◯ <1 day ◯ 1–7 days ◯ 8–14 ◯ 15–29 days ◯ Daily

14. In the past two years, have you had gastrointestinal bleeding that required hospitalization or a transfusion?

◯ Yes → **What was the site of the bleeding?**

◯ No

◯ Esophagus ◯ Stomach ◯ Duodenum ◯ Colon/rectum ◯ Other ◯ Site unknown

15. In the past two years, have you had an episode of:

a) Diverticulitis (NOT diverticulosis) diagnosed by a clinician?

◯ Yes → **If Yes, did you...** ◯ Require hospitalization? ◯ Require surgery? ◯ Have an abscess? ◯ Require antibiotics? ◯ Have a CT scan? ◯ Have more than one episode?

◯ No

b) Diverticular bleeding that required blood transfusion and/or hospitalization?

◯ No ◯ Yes

c) Diverticulosis of the colon WITHOUT diverticulitis or diverticular bleeding?

◯ No ◯ Yes

16. Do you snore?

◯ Every night ◯ Most nights ◯ A few nights a week ◯ Occasionally ◯ Almost never ◯ Don't know

17. On average, how often are your daily activities affected because you are sleepy during the day?

◯ Almost every day ◯ 4–6 days/wk ◯ 1–3 days/wk ◯ Rarely ◯ Never

18. On average, over a 24-hour period, do you sleep:

◯ <5 hours ◯ 5 hrs. ◯ 6 hrs. ◯ 7 hrs. ◯ 8 hrs. ◯ 9 hrs. ◯ 10+ hours

19. What is your highest level of education?

◯ Diploma in nursing ◯ Associate degree ◯ Bachelor's degree ◯ Master's degree ◯ Doctorate degree

20. Regular Medication *(Mark if used regularly in past 2 years.)*

◯ Acetaminophen (e.g., Tylenol)
Days/week: ◯ 1 ◯ 2–3 ◯ 4–5 ◯ 6+ days
Tablets/wk: ◯ 1–2 ◯ 3–5 ◯ 6–14 ◯ 15+ tablets

◯ Low dose aspirin (100 mg or less/tablet)
Days/week: ◯ 1 ◯ 2–3 ◯ 4–5 ◯ 6+ days
Tablets/wk: ◯ 1–2 ◯ 3–5 ◯ 6–14 ◯ 15+ tablets

◯ Aspirin or aspirin-containing products (325 mg or more/tablet)
Days/week: ◯ 1 ◯ 2–3 ◯ 4–5 ◯ 6+ days
Tablets/wk: ◯ 1–2 ◯ 3–5 ◯ 6–14 ◯ 15+ tablets

◯ Ibuprofen (e.g., Advil, Motrin, Nuprin)
Days/week: ◯ 1 ◯ 2–3 ◯ 4–5 ◯ 6+ days
Tablets/wk: ◯ 1–2 ◯ 3–5 ◯ 6–14 ◯ 15+ tablets

◯ Other anti-inflammatory (e.g., Aleve, Clinoril, Relafen, Celebrex)
Days/week: ◯ 1 ◯ 2–3 ◯ 4–5 ◯ 6+ days

◯ Thiazide diuretic ◯ Calcium blocker ◯ Beta-blocker
◯ ACE inhibitors (e.g., Lisinopril, enalapril, benazepril)
◯ Angiotensin receptor blocker (e.g., Losartan, Valsartan, Irbesartan)
◯ Spironolactone ◯ Eplerenone
◯ Other anti-hypertensive (e.g., clonidine, doxazosin, Lasix)
◯ Warfarin/Coumadin/Heparin ◯ Pradaxa/Xarelto/Eliquis/Savaysa
◯ Antiplatelet medication (e.g., Plavix, Effient, Brilinta) ◯ Antiarrhythmic

Lipid-lowering drugs: (Mark all that apply)
◯ Statin (e.g., Atorvastatin, Rosuvastatin, Simvastatin)
◯ PCSK9 inhibitor (Praluent, Repatha, Leqvio) ◯ Ezetimibe (Zetia)
◯ Other lipid-lowering drugs (e.g., fenofibrate, cholestyramine)
◯ Steroids taken orally (e.g., Prednisone, Decadron, Medrol)

Diabetes drugs: (Mark all that apply)
◯ Insulin ◯ Glucophage (Metformin)
◯ SGLT2 inhibitors (e.g., Jardiance, Farxiga, Invokana)
◯ DPP4 inhibitors (Januvia, Onglyza, Tradjenta, Nesina)
◯ Injectable/oral GLP-1 agonists (Rybelsus, Ozempic, Victoza, Trulicity)
◯ Other oral hypoglycemic agent
◯ Thyroid hormone (e.g., Synthroid, levothyroxine, Levoxyl)
◯ Triptans (e.g., Imitrex, Maxalt, Zomig, Amerge, Relpax)
◯ Prescription memory loss medications (e.g., Aricept, Exelon, Namenda, Namzaric, Aduhelm)
◯ Over-the-counter memory products
◯ Bisphosphonates (e.g., Fosamax, Boniva, Actonel)
◯ Aromatase inhibitors (e.g., Anastrozole, Exemestane)
◯ Evista (raloxifene) ◯ Tamoxifen (Nolvadex)
◯ Anticholinergics (e.g., Detrol, Ditropan, Vesicare)
◯ Antidepressant medications (e.g., SSRIs, SNRIs, Tricyclics)
◯ Benzodiazepines (e.g., Valium, alprazolam, lorazepam)
◯ ß-agonist inhaler (e.g., albuterol [Ventolin], Maxair)
◯ Prescription sleep medications (e.g., Ambien, Sonata, Lunesta)
◯ Melatonin
Dose? ◯ 1 mg or less ◯ 2–5 mg ◯ 6–10 mg ◯ over 10 mg
◯ Other over-the-counter sleep medications
◯ Prilosec, Nexium, Prevacid, Protonix, Aciphex, Dexilant
◯ H2 blocker (e.g., Pepcid, Tagamet, Zantac, Axid)
◯ Other regular medications (no need to specify)

21. What is your *current* status?

◯ Married ◯ Divorced ◯ Widowed ◯ Domestic Partnership ◯ Separated ◯ Never married

22. Your living arrangement: *(Mark all that apply.)*

◯ Alone ◯ With minor children ◯ With spouse or partner ◯ Other ◯ With other adult family ◯ With pet(s)

23. Which best describes your hearing:
○ Excellent ○ Good ○ A little hearing trouble ○ Moderate hearing trouble ○ A lot of trouble ○ Deaf

24. Do you wear a hearing aid?
○ Yes, All the time ○ Yes, Most the time ○ Yes, Occasionally ○ No, Never

25. In the past 12 months, have you had ringing, roaring, or buzzing in your ears or head?
○ Never ○ <Once/week ○ About once/week ○ Several times/week ○ Almost every day ○ Every day

a) On the days you hear the sound, how long does it last?
○ A few seconds ○ Less than 5 minutes ○ 5 minutes to an hour ○ Several hours ○ All the time

b) Does this affect your ability to: ○ Sleep ○ Work ○ Concentrate ○ Perform other activities ○ None of these

26. Has your spouse (or sleep partner) ever told you that you appear to "act out your dreams" while sleeping (punched or flailed arms in the air, shouted or screamed), on three or more occasions?
○ No ○ Yes ○ I do not have a sleep partner

27. Do you have any problems with your sense of smell, such as not being able to smell things or things not smelling the way they are supposed to for at least 3 months? (Do not include COVID-related changes to sense of smell.)
○ No ○ Yes → **Which problem do you have?** ○ Loss of smell ○ Things don't smell right ○ Don't know

28. In the last year, how often have you had heartburn or acid-reflux?
○ None in the past year ○ Less than once/month ○ About once/month ○ About once/week ○ Several times/week ○ Daily

29. In the past year, have you been bothered by constipation or diarrhea for at least 12 weeks (not necessarily consecutive)?
○ No
○ Yes, diarrhea
○ Yes, constipation
→ **If Yes, were your bowel movements associated with abdominal pain?** ○ No ○ Yes

30. Choose the best answer for how you felt during the *past month*:

Are you basically satisfied with your life?	○ Yes	○ No
Have you dropped many of your activities and interests?	○ Yes	○ No
Do you feel that your life is empty?	○ Yes	○ No
Do you often get bored?	○ Yes	○ No
Are you in good spirits most of the time?	○ Yes	○ No
Are you afraid that something bad is going to happen to you?	○ Yes	○ No
Do you feel happy most of the time?	○ Yes	○ No
Do you often feel helpless?	○ Yes	○ No
Do you feel you have more problems with memory than most?	○ Yes	○ No
Do you prefer to stay at home, rather than going out and doing new things?	○ Yes	○ No
Do you think it is wonderful to be alive now?	○ Yes	○ No
Do you feel pretty worthless the way you are now?	○ Yes	○ No
Do you feel full of energy?	○ Yes	○ No
Do you feel that your situation is hopeless?	○ Yes	○ No
Do you think that most people are better off than you are?	○ Yes	○ No

31. How many vaccinations for COVID-19 have you received?
○ Zero ○ One ○ Two ○ Three ○ Four ○ Five or more

32. Have you ever been diagnosed with COVID-19 or tested positive for COVID-19?
○ No ○ Yes →
a) Number of times you have had COVID? ○ One ○ Two ○ Three ○ Four or more
b) Were you ever hospitalized for COVID? ○ Yes ○ No
c) Have you experienced any long-term COVID-19 symptoms (lasting for more than 4 weeks)?
○ No ○ Yes → **Which of the following long-term COVID-19 symptoms have you experienced?**

○ Fatigue
○ Shortness of breath or difficulty breathing
○ Persistent cough
○ Muscle, joint or chest pain
○ Smell and taste problems
○ Confusion, disorientation, "brain fog"
○ Memory issues
○ Depression, anxiety, changes in mood
○ Heart palpitations
○ Rash, blisters or welts anywhere on body
○ Headache
○ Intermittent fever
○ Mouth or tongue ulcers
○ Tinnitus
○ Other symptoms

33. Regarding your eating habits during the past year. . .

	Never/ Rarely	Sometimes	Often	Usually/ Always
While I eat, I'm fully aware of the smells and taste of my food (e.g., temperature, texture, etc.).	○	○	○	○
I stop eating when I'm full, even if my plate is not empty yet.	○	○	○	○
I eat anything I want, whenever I want.	○	○	○	○
When I eat, I do something else on the side (e.g., read, watch TV, drive, work, be on the phone).	○	○	○	○
I try to make food and beverage choices that are good for the environment.	○	○	○	○

34. Do you currently take multivitamins? (Please report other individual vitamins in the next section.)

◯ No ◯ Yes → **a) How many do you take per week?** ◯ 2 or less ◯ 3–5 ◯ 6–9 ◯ 10 or more

b) What specific brand (or equivalent) do you most often take?

◯ Centrum Silver or Senior Vit. ◯ Centrum or generic equiv. ◯ 50+ Gummy
◯ One-A-Day 50+ or equiv. ◯ Any AREDS eye vit. ◯ Any AREDS 2 eye vit.
◯ Kirkland Signature Daily ◯ Other Multivitamins (with minerals) ◯ Other Multivitamins (without minerals) ◯ Other

Not counting multivitamins, do you take any of the following vitamin preparations?

Vitamin	No	Yes	If Yes, Dose per day:				
a) Vitamin A	◯ No	◯ Yes, seasonal only ◯ Yes, most months	◯ Less than 3,000 mcg	◯ 3,000 to 4,500 mcg	◯ 4,800 to 6,600 mcg	◯ 6,900 mcg or more	◯ Don't know
b) Potassium	◯ No	◯ Yes	◯ Less than 2.5 mEq (100 mg)	◯ 3 to 9 mEq	◯ 10 to 19 mEq	◯ 20 mEq or more	◯ Don't know
c) Vitamin C	◯ No	◯ Yes, seasonal only ◯ Yes, most months	◯ Less than 400 mg	◯ 400 to 700 mg	◯ 750 to 1250 mg	◯ 1300 mg or more	◯ Don't know
d) Vitamin B_6	◯ No	◯ Yes	◯ Less than 50 mg	◯ 50 to 99 mg	◯ 100 to 149 mg	◯ 150 mg or more	◯ Don't know
e) Vitamin E	◯ No	◯ Yes	◯ Less than 100 mg	◯ 100 to 300 mg	◯ 301 to 400 mg	◯ 401 mg or more	◯ Don't know
e) Vitamin E Type:			◯ Natural	◯ Regular (dl)	◯ Unknown		
f) Calcium (Include Calcium in Tums, etc.)	◯ No	◯ Yes	Dose per day (elemental calcium): ◯ Less than 600 mg	◯ 600 to 900 mg	◯ 901 to 1500 mg	◯ 1501 mg or more	◯ Don't know
g) Vitamin D (in calcium supplement or separately)	◯ No	◯ Yes, seasonal only ◯ Yes, most months	◯ < 1000 IU (< 25 mcg)	◯ 1000-1999 IU (25-49 mcg)	◯ 2000-4999 IU (50-124 mcg)	◯ 5000+ IU (125+ mcg)	◯ Don't know
h) Zinc	◯ No	◯ Yes	◯ Less than 31 mg	◯ 31 to 74 mg	◯ 75 to 100 mg	◯ 101 mg or more	◯ Don't know

35. Are there other supplements that you take on a regular basis?

◯ Metamucil/Citrucel ◯ Vitamin B12 ◯ Lycopene ◯ Selenium
◯ B-Complex ◯ Magnesium ◯ Glucosamine/Chondroitin ◯ Probiotics
◯ Flax Seed Oil ◯ Niacin ◯ Biotin
◯ Beta-carotene ◯ Folic Acid ◯ Coenzyme Q10 ◯ Turmeric/Curcumin
◯ Iron ◯ Fish Oil ◯ Cod Liver Oil ◯ Other → [ ]

36. How many teaspoons of sugar do you add to your beverages or food each day?

◯ Zero ◯ 1 tsp. ◯ 2 tsp. ◯ 3 tsp. ◯ 4 tsp. ◯ 5 tsp.
◯ 6 tsp. ◯ 7 tsp. ◯ 8 tsp. ◯ 9 tsp. ◯ 10 tsp.
More than 10? Write number here → [ ] tsp.

37. What brand and type of cold breakfast cereal do you most often eat? → Specify cereal brand & type (e.g., Kellogg's Raisin Bran)

◯ Don't eat cold breakfast cereal.

(0) (1) (2) (3) (4) (5) (6) (7) (8) (9)
(0) (1) (2) (3) (4) (5) (6) (7) (8) (9)
(0) (1) (2) (3) (4) (5) (6) (7) (8) (9)

38. For each food listed, fill in the circle indicating how often on average you have used the amount specified during the past year.

AVERAGE USE LAST YEAR

DAIRY FOODS	Never, or less than once per month	1–3 per month	1 per week	2–4 per week	5–6 per week	1 per day	2–3 per day	4–5 per day	6+ per day
Milk (8 oz. glass): Skim milk	◯	◯	(W)	◯	◯	(D)	◯	◯	◯
Milk (8 oz. glass): 1 or 2 % milk	◯	◯	(W)	◯	◯	(D)	◯	◯	◯
Milk (8 oz. glass): Whole milk	◯	◯	(W)	◯	◯	(D)	◯	◯	◯
Milk (8 oz. glass): Almond milk	◯	◯	(W)	◯	◯	(D)	◯	◯	◯
Milk (8 oz. glass): Soy milk	◯	◯	(W)	◯	◯	(D)	◯	◯	◯
Milk (8 oz. glass): Other plant-based milk	◯	◯	(W)	◯	◯	(D)	◯	◯	◯
Cream, e.g., coffee, sour (exclude fat free) (1 Tbs)	◯	◯	(W)	◯	◯	(D)	◯	◯	◯
Non-dairy coffee whitener (exclude fat free) (1 Tbs)	◯	◯	(W)	◯	◯	(D)	◯	◯	◯
Frozen yogurt, sherbet, or low-fat ice cream (1 cup)	◯	◯	(W)	◯	◯	(D)	◯	◯	◯
Regular ice cream (1 cup)	◯	◯	(W)	◯	◯	(D)	◯	◯	◯
Spreads added to food or bread; exclude use in cooking: Pure butter or ghee	◯	◯	(W)	◯	◯	(D)	◯	◯	◯
Spreads added to food or bread; exclude use in cooking: Margarine	◯	◯	(W)	◯	◯	(D)	◯	◯	◯
Spreads added to food or bread; exclude use in cooking: Butter with added oil (e.g., Land O Lakes Butter with Canola Oil)	◯	◯	(W)	◯	◯	(D)	◯	◯	◯
Yogurt (4–6 oz.) Include drinkable: Plain	◯	◯	(W)	◯	◯	(D)	◯	◯	◯
Yogurt (4–6 oz.) Include drinkable: Artificially sweetened (e.g., light peach)	◯	◯	(W)	◯	◯	(D)	◯	◯	◯
Yogurt (4–6 oz.) Include drinkable: Sweetened (e.g., strawberry, vanilla)	◯	◯	(W)	◯	◯	(D)	◯	◯	◯
→ **What type of yogurt do you most often eat?** *(Mark all that apply)*	◯ Greek		◯ Regular		◯ Full fat		◯ Reduced fat		
Cottage or ricotta cheese (1/2 cup)	◯	◯	(W)	◯	◯	(D)	◯	◯	◯
Cream cheese (1 oz.)	◯	◯	(W)	◯	◯	(D)	◯	◯	◯
Other cheese, e.g., American, cheddar, etc., plain or as part of a dish (1 slice or 1 oz. serving)	◯	◯	(W)	◯	◯	(D)	◯	◯	◯
→ **What type of cheese do you most often eat?**	◯ Regular	◯ Low-fat or Lite			◯ Fat free			◯ None	

CF CH FM GR HB K RB SW

S: (0)(0) (1)(1) (2)(2) (3)(3) (4)(4) (5)(5) (6)(6) (7)(7) (8)(8) (9)(9)

38. ***(continued)*** **For each food listed, fill in the circle indicating how often on average you have used the amount specified during the past year.**

Please try to average your seasonal use of foods over the entire year. For example, if a food such as cantaloupe is eaten 4 times a week during the approximate 3 months that it is in season, then the average use would be once per week.

FRUITS	Never, or less than once per month	1–3 per month	1 per week	2–4 per week	5–6 per week	1 per day	2–3 per day	4–5 per day	6+ per day
Raisins (1 oz. or small pack) or grapes (1/2 cup)			W			D			
Prunes or dried plums (1/2 cup canned or 1/4 cup dried)			W			D			
Bananas (1) or plantain (1/2)			W			D			
Cantaloupe (1/4 melon)			W			D			
Avocado (1/2 fruit or 1/2 cup)			W			D			
Fresh apples or pears (1)			W			D			
Apple juice or cider (small glass)			W			D			
Tangerines, clementines, mandarin oranges (1)			W			D			
Oranges (1)			W			D			
Orange juice (small glass): Calcium or Vit. D fortified			W			D			
Orange juice (small glass): Regular (not calcium fortified)			W			D			
Grapefruit (1/2) or grapefruit juice (small glass)			W			D			
Other fruit juices (e.g., cranberry, grape) (small glass)			W			D			
Strawberries, fresh, frozen or canned (1/2 cup)			W			D			
Blueberries, fresh, frozen or canned (1/2 cup)			W			D			
Peaches or plums (1 fresh or 1/2 cup canned)			W			D			
Apricots (1 fresh, 1/2 cup canned or 5 dried)			W			D			

VEGETABLES	Never, or less than once per month	1–3 per month	1 per week	2–4 per week	5–6 per week	1 per day	2–3 per day	4–5 per day	6+ per day
Tomatoes (2 slices)			W			D			
Tomato juice or V-8 juice (small glass)			W			D			
Tomato sauce (1/2 cup) e.g., spaghetti sauce			W			D			
Salsa, picante or taco sauce (1/4 cup)			W			D			
String beans (1/2 cup)			W			D			
Hummus (1/4 cup), garbanzo or chickpeas (1/2 cup)			W			D			
Beans or lentils, baked, dried (1/2 cup) or soup			W			D			
Soy burger, tofu, miso or other soy protein			W			D			
Other plant-based burger, e.g., Beyond Meat, Lightlife (1 patty)			W			D			
Peas or lima beans (1/2 cup fresh, frz., canned) or soup			W			D			
Broccoli (1/2 cup)			W			D			
Cauliflower (1/2 cup)			W			D			
Cabbage or coleslaw (1/2 cup)			W			D			
Brussels sprouts (1/2 cup)			W			D			
Carrots, raw (1/2 carrot or 2–4 sticks)			W			D			
Carrots, cooked (1/2 cup) or carrot juice (2–3 oz.)			W			D			
Corn (1 ear or 1/2 cup frozen or canned)			W			D			
Mixed or stir fry vegetables (1/2 cup) or soup			W			D			
Yams or sweet potatoes, include sweet potato fries, (1/2 cup)			W			D			
Dark orange (winter) squash (1/2 cup)			W			D			
Eggplant, zucchini or other summer squash (1/2 cup)			W			D			
Kale, arugula or mustard greens (1/2 cup)			W			D			
Spinach, cooked (1/2 cup)			W			D			
Spinach, raw as in salad (1 cup)			W			D			
Iceberg or head lettuce (1 serving)			W			D			
Romaine or leaf lettuce (1 serving)			W			D			
Peppers: green, yellow or red (2 rings or 1/4 small)			W			D			
Onions as a garnish or in salad (1 slice)			W			D			
Onions as a cooked vegetable or rings (1/2 cup) or soup			W			D			

EGGS, MEAT, ETC.	Never, or less than once per month	1–3 per month	1 per week	2–4 per week	5–6 per week	1 per day	2–3 per day	4–5 per day	6+ per day
Eggs (1): Omega-3 fortified including yolk			W			D			
Eggs (1): Regular eggs including yolk			W			D			
Beef hot dogs (1)			W			D			
Chicken or turkey hot dogs, sausages (1) or bacon (2 slices)			W			D			
Chicken/turkey sandwich or frozen dinner			W			D			
Other chicken or turkey, with skin (3 oz.)-including ground			W			D			
Other chicken or turkey, without skin (3 oz.)			W			D			
Bacon (exclude turkey bacon) (2 slices)			W			D			

38. ***(continued)*** **For each food listed, fill in the circle indicating how often <u>on average</u> you have used the amount specified <u>during the past year</u>.**

MEAT, FISH	Never, or less than once per month	1–3 per month	1 per week	2–4 per week	5–6 per week	1 per day	2–3 per day	4–5 per day	6+ per day
Salami, bologna, or other processed meat sandwiches			W			D			
Sausage or kielbasa (pork or beef), etc. (2 oz. or 2 links)			W			D			
Hamburger (1 patty) – Lean or extra lean			W			D			
Hamburger (1 patty) – Regular			W			D			
Beef, pork, or lamb as a sandwich or mixed dish, e.g., stew, casserole, lasagna, frozen dinners, etc.			W			D			
Pork as a main dish, e.g., ham or chops (4–6 oz.)			W			D			
Beef or lamb as a main dish, e.g., steak, roast (4–6 oz.)			W			D			
Canned tuna fish (3–4 oz.)			W			D			
Breaded fish, pieces or sticks (1 serving, store bought)			W			D			
Shellfish, e.g., shrimp, crab, scallops, clams as main dish			W			D			
Dark meat fish, e.g., tuna steak, mackerel, salmon, sardines, bluefish, swordfish (3–5 oz.)			W			D			
Other fish, e.g., cod, haddock, halibut (3–5 oz.)			W			D			

BREADS, CEREALS, STARCHES	Never, or less than once per month	1–3 per month	1 per week	2–4 per week	5–6 per week	1 per day	2–3 per day	4–5 per day	6+ per day
Cold breakfast cereal (1 serving)			W			D			
Cooked oatmeal/cooked oat bran (including instant) (1 cup)			W			D			
Other cooked breakfast cereal, including grits (1 cup)			W			D			
Bread or Pita (1 slice) – White, wheat, oatmeal (not whole grain)			W			D			
Bread or Pita (1 slice) – Rye/Pumpernickel			W			D			
Bread or Pita (1 slice) – Whole wheat, whole grain oat, whole multigrain			W			D			
Crackers (6) – Whole grain/whole wheat			W			D			
Crackers (6) – Other crackers			W			D			
Bagels, English muffins, or rolls (1)			W			D			
Muffins or biscuits (1)			W			D			
Pancakes or waffles (2 small pieces)			W			D			
Brown rice (1 cup)			W			D			
White rice (1 cup)			W			D			
Whole grain pasta, e.g., spaghetti, macaroni (1 cup)			W			D			
Other pasta (not whole grain), e.g., spaghetti, noodles, macaroni, etc. (1 cup)			W			D			
Other whole grains, e.g., quinoa, barley, spelt, etc. (1 cup)			W			D			
Tortillas: corn or flour, e.g., burritos, quesadillas etc. (2)			W			D			
French Fries, exclude sweet potato fries (6 oz. or 1 serving)			W			D			
Potatoes, baked, boiled (1) or mashed (1 cup)			W			D			
Potato chips or corn/tortilla chips (small bag or 1 oz.)			W			D			
Pizza (2 slices)			W			D			

CARBONATED BEVERAGES: Consider the serving size as 1 glass, bottle or can for these carbonated beverages.

BEVERAGES	Never, or less than once per month	1–3 per month	1 per week	2–4 per week	5–6 per week	1 per day	2–3 per day	4–5 per day	6+ per day
CARBONATED BEVERAGES – Low-Calorie (sugar-free) types – Low-calorie beverage with caffeine, e.g., Diet Coke			W			D			
CARBONATED BEVERAGES – Low-Calorie (sugar-free) types – Other low-cal bev. without caffeine, e.g., Diet 7-Up			W			D			
CARBONATED BEVERAGES – Regular types (not sugar-free) – Carbonated beverage with caffeine & sugar, e.g., Coke, Pepsi, Mt. Dew, Dr. Pepper			W			D			
CARBONATED BEVERAGES – Regular types (not sugar-free) – Other carbonated beverage with sugar, e.g., 7-Up, Root Beer, Ginger Ale, Caffeine-Free Coke			W			D			
OTHER BEVERAGES – Other sugared beverages, e.g., Punch, lemonade, sports drinks, or sugared ice tea (1 glass, bottle, can)			W			D			
Beer, regular, light or hard cider (1 glass, bottle, can)			W			D			
Red wine (5 oz. glass)			W			D			
White wine (5 oz. glass)			W			D			
Liquor, e.g., vodka, gin, hard seltzer, etc. (e.g., White Claw, Truly Seltzer, Mikes Hard Lemonade) (1 drink or shot)			W			D			
Plain water: bottled, sparkling, or tap (8 oz. cup)			W			D			
Decaffeinated tea, exclude herbal (8 oz. cup)			W			D			
Tea with caffeine, including green tea (8 oz. cup)			W			D			
Decaffeinated coffee (8 oz. cup)			W			D			
Coffee with caffeine (8 oz. cup)			W			D			
Dairy coffee drink (hot/cold), e.g., Cappuccino (12 oz.)			W			D			

38. ***(continued)*** **For each food listed, fill in the circle indicating how often on average you have used the amount specified during the past year.**

SWEETS, BAKED GOODS, MISCELLANEOUS	Never, or less than once per month	1–3 per month	1 per week	2–4 per week	5–6 per week	1 per day	2–3 per day	4–5 per day	6+ per day
Milk chocolate (bar or pack), e.g., Hershey's, M&M's	○	○	Ⓦ	○	○	Ⓓ	○	○	○
Dark chocolate, e.g., Hershey's Dark or Dove Dark	○	○	Ⓦ	○	○	Ⓓ	○	○	○
Candy bars, e.g., Snickers, Milky Way, Reese's	○	○	Ⓦ	○	○	Ⓓ	○	○	○
Candy without chocolate (1 oz.)	○	○	Ⓦ	○	○	Ⓓ	○	○	○
Cookies (1) or Brownies (1) — Ready made or from mix or dough	○	○	Ⓦ	○	○	Ⓓ	○	○	○
Cookies (1) or Brownies (1) — Home-baked, from scratch	○	○	Ⓦ	○	○	Ⓓ	○	○	○
Doughnuts (1)	○	○	Ⓦ	○	○	Ⓓ	○	○	○
Cake, homemade or ready made (slice)	○	○	Ⓦ	○	○	Ⓓ	○	○	○
Pie, homemade or ready made (slice)	○	○	Ⓦ	○	○	Ⓓ	○	○	○
Jams, jellies, preserves, syrup, or honey (1 Tbs)	○	○	Ⓦ	○	○	Ⓓ	○	○	○
Peanut butter or other nut butter (1 Tbs)	○	○	Ⓦ	○	○	Ⓓ	○	○	○
Popcorn, regular, fat free or light (2–3 cups)	○	○	Ⓦ	○	○	Ⓓ	○	○	○
Sweet roll, coffee cake or other pastry (1)	○	○	Ⓦ	○	○	Ⓓ	○	○	○
Snack bars, e.g., Kind, Kashi, granola (1)	○	○	Ⓦ	○	○	Ⓓ	○	○	○
Energy bars or high protein bars, e.g., Clif, Quest, RXbar	○	○	Ⓦ	○	○	Ⓓ	○	○	○
Diet nutrition drinks, e.g. Slimfast (1)	○	○	Ⓦ	○	○	Ⓓ	○	○	○
Ensure, Boost or other meal replacement drinks (1)	○	○	Ⓦ	○	○	Ⓓ	○	○	○
Pretzels (1 small bag or serving)	○	○	Ⓦ	○	○	Ⓓ	○	○	○
Peanuts (small packet or 1 oz.)	○	○	Ⓦ	○	○	Ⓓ	○	○	○
Walnuts (1 oz.)	○	○	Ⓦ	○	○	Ⓓ	○	○	○
Other nuts (small packet or 1 oz.)	○	○	Ⓦ	○	○	Ⓓ	○	○	○
Dried cranberries (1/4 cup)	○	○	Ⓦ	○	○	Ⓓ	○	○	○
Mixed dried fruit (1/4 cup)	○	○	Ⓦ	○	○	Ⓓ	○	○	○
Oat bran, other bran (wheat, etc.), added to food (1 Tbs)	○	○	Ⓦ	○	○	Ⓓ	○	○	○
Chowder or cream soup (1 cup)	○	○	Ⓦ	○	○	Ⓓ	○	○	○
Tomato soup (1 cup)	○	○	Ⓦ	○	○	Ⓓ	○	○	○
Ketchup or red chili sauce (1 Tbs)	○	○	Ⓦ	○	○	Ⓓ	○	○	○
Flaxseed (1 Tbs)	○	○	Ⓦ	○	○	Ⓓ	○	○	○
Seeds, e.g., pumpkin, sunflower, etc. (1/4 cup)	○	○	Ⓦ	○	○	Ⓓ	○	○	○
Garlic, fresh or powdered (1 clove or 4 shakes)	○	○	Ⓦ	○	○	Ⓓ	○	○	○
Olives, any type (3)	○	○	Ⓦ	○	○	Ⓓ	○	○	○
Olive oil added to food or bread (1 Tbs)	○	○	Ⓦ	○	○	Ⓓ	○	○	○
Low-fat or olive oil mayonnaise (1 Tbs)	○	○	Ⓦ	○	○	Ⓓ	○	○	○
Regular mayonnaise (1 Tbs)	○	○	Ⓦ	○	○	Ⓓ	○	○	○
Salad dressing (1–2 Tbs) — How often?	○	○	Ⓦ	○	○	Ⓓ	○	○	○
Artificial sweeteners (1 packet) — How often?	○	○	Ⓦ	○	○	Ⓓ	○	○	○

Salad dressing Type(s): ○ Nonfat ○ Low-fat ○ Olive oil ○ Regular (e.g., Italian, Ranch)

Artificial sweeteners Type(s): ○ Splenda ○ Equal ○ NutraSweet ○ Sweet'N Low ○ Truvia ○ Stevia

39. Liver: beef, calf or pork (4 oz.) ○ Never ○ Less than 1/mo ○ 1/mo ○ 2–3/mo ○ 1/week or more

Liver: chicken or turkey (4 oz.) ○ Never ○ Less than 1/mo ○ 1/mo ○ 2–3/mo ○ 1/week or more

40. How often do you eat pan-fried or sautéed food at home? (Exclude "Pam"-type spray)

○ Less than once a week ○ 1–3 times per week ○ 4–6 times per week ○ Daily

41. What kind of fat is most often used for pan-frying and sautéing at home? (Exclude "Pam"-type spray)

○ Real butter ○ Margarine ○ Olive oil ○ Vegetable oil ○ Veg. shortening ○ Lard ○ N/A

42. What kind of fat is most often used for baking COOKIES at home?

○ Real butter ○ Margarine ○ Olive oil ○ Vegetable oil ○ Veg. shortening ○ Lard ○ N/A

43. What type of cooking oil is most often used at home? (e.g., Mazola Corn Oil) Specify brand and type

44. How often do you eat deep fried chicken, fish, shrimp, clams or onion rings away from home?

○ Less than once a week ○ 1–3 times per week ○ 4–6 times per week ○ Daily

45. How often do you eat toasted breads, bagel or English muffin (slice or 1 half bagel)?

○ Less than once a week ○ 1–3 times per week ○ 4–6 times per week ○ Daily ○ 2+ times/day

46. Are you following any of these diets? *(Mark all that apply.)*

○ Low carb (Atkins, Paleo, etc.) ○ Vegetarian ○ Low sodium ○ Diabetic ○ Mediterranean
○ Keto ○ Gluten free ○ Low calorie ○ Intermittent fasting ○ Other
○ Vegan ○ Low fat ○ Weight Watchers ○ DASH ○ None

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