

For office use only:

Child ID _____ Child's Initials _____

MAYO CLINIC FAMILY DEMOGRAPHIC SURVEY

If you are uncomfortable with answering a question, please mark an "X" in the box next to your answer. If you feel

Yes No Don't Know

Your Age: _____ years

Male Female

Married Separated Widowed

American Indian Alaska Native Hispanic/Latino Other

Your Education: Less than High School Diploma High School Diploma or GED Some College or Associate Degree Bachelor's Degree Graduate Degree

Additional Information (This will only be used by the research team to obtain full questionnaire information)

Your Name: Mr. Mrs. Ms. (First) _____ (Last) _____

Your Email Address: _____

Home Phone Number: (____) _____

Work Phone Number: (____) _____

(City, State & ZIP Code) _____

Child's Name: _____ Child's Date of Birth: _____ Child's Sex: _____

Child's Address: _____

For office use only: Survey date: ____ - ____ - ____

Visit: ___ Initial ___ 6 month ___ 12 month

Child ID _____ Child's Initials _____

Ways I Can Stay Healthy

Circle one answer: At least: 0 1 2 3 4 5 (servings)

4 5 (cups)

Circle one answer: 0 1 2 3

For office use only: Survey date: ____ - ____ - ____

Visit: ___ Initial ___ 6 month 12 month

Child ID _____ Child's Initials _____

(Survey continued)



Circle one answer: At least: 0 1 2 3 4 5 (hours)



Child ID _____

Child's Initials _____

Please print clearly

We are interested in the health and nutritional habits of your child. On your child's present birthday, please circle ONE response for each question.

1. How many servings of fruits or vegetables does your child eat a day? (One serving is most easily identified by the size of the palm of your child's hand.)

1. How many servings of fruits or vegetables does your child eat a day? (One serving is most easily identified by the size of the palm of your child's hand.)

0	1	2	3	4	5 or more		
1	2	3	4	5	6	7 or more	0

2. How many times a week does your child eat breakfast?

3. How many times a week does your child eat dinner?

1	2	3	4	5	6	7	0
0	1	2	3	4	5	6	7 or more

0	1	2	3	4	5 or more	100% Juice
0	1	2	3	4	5 or more	Fruit drinks or sports drinks
0	1	2	3	4	5 or more	Soda or punch
0	1	2	3	4	5 or more	Water
0	1	2	3	4	5 or more	Nonfat or reduced fat milk
0	1	2	3	4	5 or more	Whole milk

0	1	2	3	4	5	6	7 or more
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Today's date: ___/___/_____

Modified E.O. 14176 Health Habits Questions (in continued)

7. How much dinner (or other meals) does your child eat each day (includes breastfeeding or weaning)?

_____ None 1-2 times 3-4 times 5-6 times 7-8 times 9-12 times or more

8. How many hours of sleep does your child get each night?

Less than 4 hours 5 6 7 8 9 All or more

9. Does your child have a TV in the room where he/she sleeps?

Yes No

10. Based on your answers, is there ONE thing you would like to help your child change?

Eat more fruits & vegetables.

_____ Spend less time watching TV (less than 1 hour a day).

_____ Spend more time playing outside.

Eat less fast food/takeout.

Play outside more often.

_____ Drink less soda, juice, or punch.

_____ Switch

to skim or low fat milk.

_____ Drink more

water.

_____ Other _____