Modification of Diet in Renal Disease Study

NUTRITION HISTORY

PURPOSE:

1. To provide background information relative to the social environment of food consumption, such as where and when food is eaten, who is involved in preparation, what facilities are available for food storage and preparation, whether the patient has particular food likes and dislikes.

2. To assess the patient's experience with food/diet related issues.

3. To evaluate the patient's willingness and ability to follow instructions and record information.

INSTRUCTIONS:

1. The Nutrition History Questionnaire Form is in two parts. Form 78-P is completed by the patient and is not coded. Form 78 is to be coded from the answers provided by the patient on Form 78-P and entered into Datalex.

2. Give Form 78-P to the patient at the Screening Visit. It is to be completed by the patient before the next visit.

3. Review Form 78-P with the patient to make sure it can be understood.

4. Attach a stamped addressed envelope for mailing to the Clinical Center or ask the patient to bring it to the next visit.

5. When the patient returns Form 78-P, code and complete Form 78 which is to be entered into Datalex. Enter the codes, as answered by the patient on Form 78-P, for questions 5, 6, 7, and 8. NOTE for item 8a and b (Form 78): If the answer to 8a (Does the patient live with other family members?) is yes yet the other member is, for example, an infant, item 8b is then not applicable. In such instances, leave item 8b blank.

6. Retain the Nutrition History Form 78-P in the patient's file.

For DCC Use Only
Rev. 4 3/27/90

E___
V___
T___

MDRD

Modification of Diet in Renal Disease Study
Nutrition History Questionnaire

This form should be completed by transcribing the patient's responses to Form 78-P.
(Note: This form should be entered into Datalex)

FORM # 7 8

1. Patient Identification Number ..... ___ ___ ___ ___ ___ ___
2. Patient Name Code ..... ___ ___ ___ ___
3. Clinical Center ..... ___ ___
4. a. Date form given to patient ..... ___ ___/___ ___/___ ___
   b. Visit Type ..... ___
   c. Visit Number ..... ___ ___ . ___
5. Has the patient followed a special diet in the past? (1 = yes, 2 = no) ..... ___

If no, skip to item 6. If yes, code which diet(s) were followed (1 = yes, 2 = no):.

a. Low calorie, weight loss ..... ___
b. Low fat/Low cholesterol ..... ___
c. Low protein ..... ___
d. Low sugar/Diabetic ..... ___
e. High fiber ..... ___
f. Low salt ..... ___
g. Low potassium ..... ___
h. Other: _____ ..... ___

Who taught the patient the diet(s)? (For the following: 1 = yes, 2 = no)

i. Doctor ..... ___
j. Nurse ..... ___
k. Relative ..... ___
l. Dietitian ..... ___
m. No one ..... ___
n. Other (example: Weight Watchers): _____ ..... ___
o. What was the last year the patient was on the diet? ..... ___ ___ ___ ___
p. How long did the patient follow the diet? (Months) ..... ___ ___ ___

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6. Is the patient <u>now</u> following (or trying to follow) any special diet? (1 = yes, 2 = no) ....___

If no, skip to item 7. If yes, code which diet(s) were followed (1 = yes, 2 = no):.

30 Calorie Restriction

a. Low calorie, weight loss ....___

b. Low fat/Low cholesterol ....___

BQ Diet Restriction

c. Low protein ....___

d. Low sugar/Diabetic ....___

e. High fiber ....___

f. Low salt ....___

g. Low potassium ....___

h. Other:_____ ....___

Who recommended the special diet? (For the following, 1 = yes, 2 = no)

i. Doctor ....___

j. Nurse ....___

k. Dietitian ....___

l. No one ....___

Who taught the patient the diet(s)? (For the following, 1 = yes, 2 = no)

m. Doctor ....___

n. Nurse ....___

o. Relative ....___

p. Dietitian ....___

q. No one ....___

r. Other (example: Weight Watchers):_____ ....___

s. When did the patient receive the instructions (approximate date)?___ ___/___ ___/___ ___

t. Does the patient have difficulty following this diet? (1 = yes, 2 = no) ....___

If yes, please describe the difficulties:

_____

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7. a. Does the patient live with a spouse or significant other? (1 = yes, 2 = no).....___

If no, skip to item 8a. If yes,

b. How supportive does the patient think his/her spouse/significant other/person(s) with whom he/she lives would be if he/she were asked to make changes in his/her diet? (Circle one number on the scale below.)

Not Supportive	1	2	3	4	5	Very Supportive

8. a. Does the patient live with other family members? (1 = yes, 2 = no).....___

If no, skip to item 101. If yes,

b. How supportive does the patient think other family members would be if he/she were asked to make changes in his/her diet? (Circle one number on the scale below.)

Not Supportive	1	2	3	4	5	Very Supportive

101. Date this form completed.....___ ___/___ ___/___ ___

102. Certification number of person filling out this form .....___ ___ ___ ___ ___

103. Date form entered.....___ ___/___ ___/___ ___

104. Certification number of data entry person .....___ ___ ___ ___ ___

Retain a copy of this form for your files. Send the original to the MDRD Study Data Coordinating Center. *Do not send this form to the NCC.* Please use MDRD Study mailing labels:

MDRD Study Data Coordinating Center
Department of Biostatistics & Epidemiology
The Cleveland Clinic Foundation
9500 Euclid Avenue
Cleveland, Ohio 44195-5196

Name: _____
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MDRD

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This questionnaire will give the dietitian useful information about your weight, occupation, and eating habits. Your answers and comments will help the dietitian and you to design an eating pattern that includes foods you enjoy.

Please mail the completed form to your MDRD center in the self-addressed stamped envelope provided. In this way the dietitian can review the form before your next visit.

Please use a ballpoint pen - not felt tip - to complete this form.

1. Are you:
   - ___Employed, full time
   - ___Employed, part time
   - ___A homemaker
   - ___Unemployed
   - ___Retired
   - ___On disability
   - ___Other: _____

   If you are not employed, skip to question 3.

2. If you are employed:
   a. Does your job require that you travel?..... ___Yes ___No

   b. If yes, does travel involve overnight stay? ..... ___Yes ___No

   c. How often does the travel involve an overnight stay? ___Weekly ___Monthly ___Few/Year

3. Do any of your business or social functions include meals or refreshments?..... ___Yes ___No

   If no, go on to question 4.

   b. If yes, how many times a month? ..... ___ ___

4. Describe other work or activities you do at home or somewhere else (for example: housework, yard work, or volunteer work).

   _____

   _____

5. Have you followed a special diet in the past?..... ___Yes ___No

   (Questions regarding your current intake follow)

   If no, go on to question 6. If yes, check which one(s).

   - ___Low calorie, weight loss
   - ___Low fat/low cholesterol
   - ___Low protein
   - ___Low sugar/diabetic
   - ___High fiber
   - ___Low salt
   - ___Low potassium
   - ___Other: _____

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5. (Continued)
   a. Who taught you the diet(s)?

___Doctor
___Nurse
___Relative
___Dietitian
___No one
___Other (Example Weight Watchers) _____

   b. When and how long did you follow the diet..... _____

   c. When and why did you stop following the diet..... _____

_____

6. Are you now following (or trying to follow) any special diet? ..... ___Yes ___No

   If no, go on to question 7. If yes, check which one(s).

___Low calorie, weight loss
___Low fat/low cholesterol
___Low protein
___Low sugar/diabetic
___High fiber
___Low salt
___Low potassium
___Other: _____

   a. Who recommended the special diet? (example: doctor, nurse, no one, started diet on your own) _____

   b. Who taught you the diet(s)?

___Doctor
___Nurse
___Relative
___Dietitian
___No one
___Other (Example Weight Watchers) _____

   b. When did you receive the instructions? (approximate date)..... _____

   c. When and why did you stop following the diet..... _____

_____

   d. Do you have difficulty following this diet?..... ___Yes ___No

   If yes, please describe the difficulties: ..... _____

_____

7. How supportive would your spouse/significant other be if you were asked to make changes in your diet? (Circle one number on the scale below.)

   Check here if this question does not apply to you ..... ___

Not Supportive	1	2	3	4	5	Very Supportive

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8. How supportive would your other family members/people with whom you live be if you were asked to make changes in your diet? (Circle one number on the scale below.)

   Check here if this question does not apply to you ..... ___

Not Supportive	1	2	3	4	5	Very Supportive

9. Who usually prepares your meals at home _____

   a. For how many people? _____

10. Who usually does the grocery shopping? _____
    (relationship to you)

    a. Do you or whomever shops have any problems shopping for food? ..... ___Yes ___No

    If yes, please explain: _____

    _____

11. Please list the people with whom you live and indicate if they follow a special diet:

    If you live alone, check here and go on to Question 12 ..... ___

    Name/Relationship — Type of Special Diet (if applicable)

    _____

    _____

    _____

12. During the past year, has your weight:

    a. ___Increased. By how many pounds? ..... _____

    b. ___Decreased. By how many pounds? ..... _____

    c. ___Remained about the same.

13. What do you think is the best weight for you? ..... _____pounds

    a. Have you ever weighed your best weight? ..... ___Yes ___No

    b. If so, how old were you? ..... _____years

14. What is the most you have ever weighed (not counting pregnancy)? .... _____pounds

    a. How old were you? ..... _____years

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15. What is the least you have weighed since age 20? ..... _____ pounds

    a. How old were you? ..... _____ years

16. Do you lose weight easily? ..... ___Yes ___No

17. Have you ever tried to gain weight? ..... ___Yes ___No

18. Are you satisfied with your weight now? ..... ___Yes ___No

19. Over the past year, how often have you begun a weight loss program? Number of times ..... _____

20. How often do you use the following methods as a way to lose weight? Write one number from the scale below after each method.

1 Never	2 Rarely	3 Sometimes	4 Often	5 Always

    a. Skip meals ..... ___
    b. Fasting ..... ___
    c. Low carbohydrate ..... ___
    d. Low fat ..... ___
    e. Smaller portions ..... ___
    f. Quick weight loss diets ..... ___ (such as Cambridge, HerbaLife)
    g. Special products ..... ___ (such as Dexatrim, laxatives, etc.)
    h. Reduce calories ..... ___
    i. Diet camps/spas ..... ___
    j. Special diet programs ..... ___ (such as Nutri-Med, Opti-Fast, NutriSystem)
    k. High protein ..... ___
    l. Other: _____ (please indicate what)

21. Have you ever had an "eating binge" (eating a large amount of food in a short period of time)? ..... ___Yes ___No

    If yes, please describe _____

22. How many breakfasts do you eat in a typical week? ..... _____

    If you do not eat breakfast, write in "0". Go on to Question 23.

    a. How many are prepared and eaten at home? ..... _____

    b. How many are eaten out? ..... _____

    c. Using the list in the box, please indicate where you eat breakfast out by circling the number(s) which apply:

1 = Prepared at home, but eaten out (such as lunch at work)	
2 = Restaurant	5 = Cafeteria
3 = Fast food	6 = Vending machine
4 = Take out	7 = At relative's/friend's home

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23. How many lunches do you eat in a typical week? _____

If you do not eat lunch, write in "0". Go on to Question 24.

a. How many are prepared and eaten at home? _____

b. How many are eaten out? _____

c. Using the list in the box, please indicate where you eat lunch out by circling the number(s) which apply:

1 = Prepared at home, but eaten out (such as lunch at work)	
2 = Restaurant	5 = Cafeteria
3 = Fast food	6 = Vending machine
4 = Take out	7 = At relative's/friend's home

24. How many dinners do you eat in a typical week? _____

If you do not eat dinner, write in "0". Go on to Question 25.

a. How many are prepared and eaten at home? _____

b. How many are eaten out? _____

c. Using the list in the box, please indicate where you eat dinner out by circling the number(s) which apply:

1 = Prepared at home, but eaten out (such as lunch at work)	
2 = Restaurant	5 = Cafeteria
3 = Fast food	6 = Vending machine
4 = Take out	7 = At relative's/friend's home

25. Do you eat snacks and/or drink beverages, other than water, between meals? ___Yes ___No

If no, go on to Question 26.

a. How often (example: twice a day, three times a week)? _____

b. What time(s) of the day/night? _____

c. What kind of snack(s) or beverage(s)? _____

_____

_____

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26. Do you ever drink alcoholic beverages?..... ___Yes ___No

If no, go on to question 27.

If yes, list the average amount of the following types of beverage and how often you have them (for example, 4 oz. of wine 6 days per week).

Beverage	Average Amount	How Often
Wine	_____	_____
Beer	_____	_____
Mixed drinks	_____	_____

27. Has there ever been a time when drinking (alcohol) has interfered with your work, home, or social life?..... ___Yes ___No

28. How often do you add salt to your food <u>at the table</u>?

___Never
___Occasionally
___At every meal
___Rarely
___Nearly always

29. How often do you add a salt <u>substitute</u> to your food <u>at the table</u>?

___Never
___Occasionally
___At every meal
___Rarely
___Nearly always

Which brand do you use?_____

30. How often is salt added to your food <u>during cooking</u>?

___Never
___Occasionally
___At every meal
___Rarely
___Nearly always

31. How often is a salt <u>substitute</u> added to your food during cooking?

___Never
___Occasionally
___At every meal
___Rarely
___Nearly always

32. How often do you feel you make healthy food choices? (Circle one number on the scale below.)

Not Often at All	1	2	3	4	5	Very Often

33. Do you wear dentures? ..... ___Yes ___No

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34. Do you have any chewing problems? ..... ___Yes ___No

If yes, describe the problem (such as what you are not able to eat).

_____

_____

35. Do you have any swallowing problems (example: a problem taking pills)? ..... ___Yes ___No

36. Which of the following do you have at home or otherwise available for your use? Please check:

___Stove
___Freezer
___Blender
___Hot plate
___Food scale
___Personal computer
___VCR
___Refrigerator
___Food processor
___Toaster oven
___Microwave
___Body scale
___Calculator

37. Are you now taking any vitamin, mineral, or other supplements (such as: multi-vitamin, One-A-Day, fish oil capsules, vitamin E, medicinal herbs, etc.)? ..... ___Yes ___No

If no, skip to item 38.

If yes, please list the supplement(s), how much you take, how often, and who recommended the supplement(s). (Provide labels if available.)

Supplement	Amount	How Often	Who Recommended It
Example: Vitamin C	*250 mg*	*one per day*	*friend*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

38. Are there any foods you don't eat because you are allergic to or can't tolerate them? ..... ___Yes ___No

If yes, please list the foods:

_____

_____

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39. Are there any foods you don't eat because you just don't like them? ..... ___Yes ___No

If yes, please list the foods:

_____

_____

40. Are there any foods you don't eat because of religious or other reasons? ..... ___Yes ___No

If yes, please list the foods:

_____

_____

41. What are some of your favorite foods?

_____

_____

_____

_____

42. Did you fill out this form yourself? ..... ___Yes ___No

If no, who helped you? _____

Thank you.