



**NIP DIABETES PILOT TRIAL
FOOD FREQUENCY QUESTIONNAIRE FORM**

Form NPP22
15Nov2007 (v.1.2)
Page 1 of 3

Site Number: _____ Screening ID: _____ - ____ Participant Letters: _____ Visit Date: ____/____/____

INSTRUCTIONS:

- Complete this form at the following study visits: Pregnancy Screening/Enrollment Visit, Infant Screening Visit, Infant Enrollment Visit, 3, 6, 9, and 12 Months Old Visits.
- Section A completed by Study Personnel.
- Sections B and C completed by the mother if she entered the study when pregnant (Entry A) or is currently breastfeeding her baby.
- Study Personnel will collect the completed questionnaire from you before leaving, review your responses, and initial and date the form.
- If you have any questions about this questionnaire, please ask study personnel.

TO BE COMPLETED BY STUDY PERSONNEL:

A. VISIT INFORMATION

1. Date of visit (e.g. 05/Sep/2005):

____	/	____	/	____
DAY		MONTH		YEAR

2. For which visit is this form being completed (check one)?

a. Category (check one):

	Entry A (All Mothers)	Entry B (Nursing Only)	Entry A & B (Nursing Only)
<input type="checkbox"/> ₉₁ Pregnancy Screening/Enrollment			
<input type="checkbox"/> ₁ Infant Screening	<input type="checkbox"/> ₁		
<input type="checkbox"/> ₂ Infant Enrollment	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	
<input type="checkbox"/> ₉₃ Infant Enrollment combined with 3 Months Old	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	
<input type="checkbox"/> ₉₄ Infant Enrollment combined with 6 Months Old	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	
<input type="checkbox"/> ₉₅ Entry A Infant Screening combined with Infant Enrollment	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	
<input type="checkbox"/> ₃ 3 Months Old			<input type="checkbox"/> ₃
<input type="checkbox"/> ₆ 6 Months Old			<input type="checkbox"/> ₃
<input type="checkbox"/> ₉ 9 Months Old			<input type="checkbox"/> ₃
<input type="checkbox"/> ₁₂ 12 Months Old			<input type="checkbox"/> ₃

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Write "*" if the desired information is permanently unavailable (i.e. will not be known in any future updates).*



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Site Number: _____ Screening ID: _____ - ____ Participant Letters: _____ Visit Date: ____/____/____

TO BE COMPLETED BY MOTHER:

B. FOOD FREQUENCY QUESTIONNAIRE

Record how often you ate the following foods for the last 3 months. This includes all meals or snacks, at home, in a restaurant or carry-out.

HOW OFTEN (in the last 3 months)

	Never	Once per 3 months	Once per month	2-3 times per month	Once per week	2 times per week	3-4 times per week	5-6 times per week	Every day
1. Fish sticks, fried fish, or fish sandwich	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9
2. Tuna, tuna salad, or tuna fish casserole	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9
3. Oysters	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9
4. Other shellfish like shrimp, scallops, crab	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9
5. Salmon	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9
6. Halibut	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9
7. Trout	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9
8. Mackerel	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9
9. Herring	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9
10. Sardines	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9
11. Other white fish such as cod, sole, flounder, catfish, perch, haddock	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9

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TO BE COMPLETED BY MOTHER:

C. SPECIAL FOOD PRODUCTS

If you have eaten any special food products with added DHA or omega-3 fatty acids in the last 3 months, please write clearly the food, brand name, and check how often.

c. HOW OFTEN (in the last 3 months)

	a. Food	b. Brand	Never	Once per 3 months	Once per month	2-3 times per month	Once per week	2 times per week	3-4 times per week	5-6 times per week	Every day
1.			<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9
2.			<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9
3.			<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9
4.			<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9
5.			<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9

Initials (first, middle, last) of Study Personnel reviewing this form: _____
F M L

Date form completed: ____/____/____
DAY MONTH YEAR

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