

Name: _____ Age: _____

Does anyone in your family have diabetes?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Don't know	Who: _____
Does anyone in your family have high blood pressure?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Don't know	Who: _____
Has anyone in your family had a heart attack or stroke?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Don't know	Who: _____
Do you think anyone in your family is overweight (weighs more than is considered healthy)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Don't know	Who: _____

	How many servings of fruits and vegetables do you eat?	0-1 servings	2-3 servings	4-5 servings	More than 5 servings
	In total, how many hours per day do you watch TV or movies, or play video or computer games?	More than 4 hours	3-4 hours	1-2 hours	1 hour or less
	How many days per week are you physically active for at least one hour, not including school time? (For example: walking, running, biking, swimming, playing outside, dancing, soccer, etc.)	0-1 days	2-3 days	4-5 days	6-7 days
	How many times each week does your family do something active together?	0-1 days	2-3 days	4-5 days	6-7 days
	How many times per day do you drink: juice, soda, sports drinks, energy drinks, flavored milk, lemonade, sweetened tea or coffee drinks?	4 or more times	3 times	1-2 times	0 times
O T H E R	How many times each week do you eat breakfast?	0-1 times	2-3 times	4-5 times	6-7 times
	How many times a week do you eat fast food or go to a restaurant?	6-7 times	4-5 times	2-3 times	0-1 times
	How many days per week does your family eat together at the table?	0-1 times	2-3 times	4-5 times	6-7 times
	Are you having any difficulty sleeping?	Often	Sometimes	Rarely	Never
	How worried are you about your health?	Often	Sometimes	Rarely	Never
	How worried are you about your weight?	Often	Sometimes	Rarely	Never