



Participant ID:

Participant Initials:

Site:

Visit Number:

CRF Date:

RC ID:

WEIGHT HISTORY

Display Name- 7 Days: Weight History

Please answer the following questions about your weight:

1. What is the most you have ever weighed?	_____lb
a. How old were you when you first weighed that much?	_____ Age in years
2. Would you consider yourself now:	
Much too thin <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 Much too fat	
3. What is your belief about the effect of being overweight on health?	
Harmless <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 Very Harmful	
Thank You for Completing this Questionnaire	

For Research Coordinator use only: CRF was: Self-administered Interviewer-administered