



1) How many full sisters and brothers (share both parents) do you have? _____

2) How many half sisters and brothers (share 1 of 2 parents) do you have? _____

These questions are only about your biological family.

Do not include people living with you who are not directly related to you.

3) Do any of the following members of your family have diabetes?

Mother Yes No Father Yes No

- a. How many full sisters and brothers have diabetes? None 1 2 3+
- b. How many half sisters and brothers have diabetes? None 1 2 3+
- c. How many grandparents have diabetes? None 1 2 3+

4) Do any members of your family have high blood pressure (hypertension)?

Mother Yes No Father Yes No

- a. How many full sisters and brothers have high blood pressure? None 1 2 3+
- b. How many half sisters and brothers have high blood pressure? None 1 2 3+
- c. How many grandparents have high blood pressure? None 1 2 3+

5) Do any members of your family have high cholesterol (hyperlipidemia)?

Mother Yes No Father Yes No

- a. How many full sisters and brothers have high cholesterol? None 1 2 3+
- b. How many half sisters and brothers have high cholesterol? None 1 2 3+
- c. How many grandparents have high cholesterol? None 1 2 3+

6) Have any members of your family ever had a stroke?

Mother Yes No Father Yes No

- a. How many full sisters and brothers have had a stroke? None 1 2 3+
- b. How many half sisters and brothers have had a stroke? None 1 2 3+
- c. How many grandparents have had a stroke? None 1 2 3+

7) Have any members of your family ever had angina (chest pain) or a heart attack?

Mother Yes No Father Yes No

- a. How many full sisters and brothers have had either? None 1 2 3+
- b. How many half sisters and brothers have had either? None 1 2 3+
- c. How many grandparents have had either? None 1 2 3+

8) Have any members of your family ever had heart/bypass surgery?

Mother Yes No Father Yes No

- a. How many full sisters and brothers have had heart/bypass surgery? None 1 2 3+
- b. How many half sisters and brothers have had heart/bypass surgery? None 1 2 3+
- c. How many grandparents have had heart/bypass surgery? None 1 2 3+

9) **Before the age of 65,**
Have any female members of your family had angina, heart attack,
heart/bypass surgery or a stroke ?

Mother Yes No Grandmothers Yes No

10) **Before the age of 55,**
Have any male members of your family had angina, heart attack,
heart/bypass surgery or a stroke ?

Father Yes No Grandfathers Yes No



- 1) What is your height? weight?
- 2) Are you trying to, or have you ever tried to lose weight? Yes No
- 3) Would you like to:
 Weigh more Weigh less Have weight stay about the same
- 4) Compared to other students in your grade who are as tall as you, do you think you weigh:
 The right amount Too much Too little
- 5) Has your doctor or nurse practitioner ever told you that you have diabetes? Yes No
 If no, skip to question 6.
 a. If yes to 4, are you taking medication to control your diabetes other than insulin? Yes No
 b. If yes to 4, are you taking insulin to control your diabetes? Yes No
- 6) Has your doctor or nurse practitioner ever told you that you have high blood pressure (*hypertension*)? If no, skip to question 7.
 a. If yes to 5, are you taking medication to control your blood pressure? Yes No
- 7) Has your doctor or nurse practitioner ever told you that you have high cholesterol (*hyperlipidemia*)? If no skip to question 8.
 a. If yes to 6, are you taking medication to control your high cholesterol? Yes No
- 8) Has your doctor or nurse practitioner ever told you that you have low HDL cholesterol (*good cholesterol*)? Yes No
- 9) How would you rate your overall health? Poor Fair Good Very Good Excellent
- 10) How would you rate your stress level? Poor Fair Good Very Good Excellent
- 11) Do you take a vitamin pill? If no go to next section. Yes No
- 12) Do you take a multivitamin and what strength is the Niacin (Vitamin B3)? Yes No Don't know
 50 mg 100 mg
- 13) Do you take a B Complex vitamin that contains Niacin and what strength is the Niacin? Yes No Don't know
 50 mg 100 mg
- 14) How often do you take the vitamin that contains Niacin per week? 0-1 1-2 3-6 8 or more

smoking

Contact www.smokershotline.ca

- 1 - Do any of your family members smoke?
Yes No
- 2 - Does anyone smoke in your home?
 a) No - Our house is a smoke-free house
 b) No - But guests do
 c) Yes - In most areas
 d) Yes - In designated smoking room
 e) Yes - Outside only
- 3 - Do your friends smoke?
Yes No
- 4 - Have your friends ever tried smoking, even just a few puffs?
Yes No
- 5 - If one of your friends asked you to smoke a cigarette, would you?
Yes No
- 6 - Do you smoke?
Yes No
 (If you answered no, go to question 11)
- 7 - Think about the last 30 days. Did you smoke a cigarette, even a puff?
 a) Everyday or almost every day
 b) Some days
 c) 1 or 2 days
 d) None at all
- 8 - Would you consider yourself to be a:
 a) Ex-smoker who has totally quit
 b) Non-smoker, who sometimes smokes
 c) Light smoker
 d) Medium smoker
 e) Heavy smoker
- 9 - Think about the last 30 days. On the days that you smoked, how many cigarettes did you smoke?
 a) A few puffs only
 b) 1 - 2 per day
 c) 3 - 5 per day
 d) 6 - 10 per day
 e) 11 - 19 per day
 g) 20 or more per day
- 10 - Think about the next 6 months. Do you plan on quitting smoking?
 Yes No
 If Yes check one
 a) Within the next week
 b) Within the next month
 c) Within the next 3 months
 d) More than 3 months from now
- 11 - If you are an ex-smoker, how long have you been smoke free?
 a) More than a year
 b) Between 6 months and one year
 c) Less than 6 months
 d) I still consider myself a smoker

25. **What kind of milk do you usually drink?**
- Regular (whole) milk
 - Low-fat (2%, 1 ½%, 1%) milk
 - Skim, nonfat, or ½% milk
 - Soy, almond or rice milk
 - Combination of the above types of milk
 - I don't drink milk
26. **Are you a vegetarian?**
- No, I eat meat (beef, pork, fish, or chicken).
 - Yes, but sometimes I eat meat (beef, pork, fish, or chicken).
 - Yes, I never eat meat (beef, pork, fish, or chicken).
27. **When you think about the way you usually eat, would you say that your eating habits are:**
- Much healthier than those of most people my age
 - Somewhat healthier than those of most people my age
 - About the same as those of most people my age
 - Somewhat less healthy than those of most people my age
 - Much less healthy than those of most people my age
28. **Do you usually eat or drink something for breakfast?**
- Almost always or always
 - Sometimes
 - Almost never or never
- 29.. **How many times do you skip breakfast in one week?**
 _____ / 7 days
30. **Do you skip meals?**
- Yes No
31. **Do you buy lunch at work (for example, cafeteria or outside restaurant) instead of bringing a lunch from home?**
- Almost always or always
 - Sometimes
 - Almost never or never
 - Not applicable
32. **Other than the work cafeteria, how many times do you eat out in a restaurant or fast food place?**
 _____ / 7 days
33. **From which food group SHOULD you eat the MOST servings each day?**
- | | |
|--|--|
| <input type="checkbox"/> Breads, cereals, rice, pasta | <input type="checkbox"/> Meats, fish, poultry, |
| <input type="checkbox"/> Dairy products (milk, cheese, yogurt) | beans, eggs, nuts, |
| <input type="checkbox"/> Fats, oils, sweets | <input type="checkbox"/> Don't know |
| <input type="checkbox"/> Fruits and vegetables | |
34. **From which food group SHOULD you eat the FEWEST servings each day?**
- | | |
|--|--|
| <input type="checkbox"/> Breads, cereals, rice, pasta | <input type="checkbox"/> Meats, fish, poultry, |
| <input type="checkbox"/> Dairy products (milk, cheese, yogurt) | beans, eggs, nuts, |
| <input type="checkbox"/> Fats, oils, sweets | <input type="checkbox"/> Don't know |
| <input type="checkbox"/> Fruits and vegetables | |
35. **How many total servings of fruits and vegetables should you eat each day?**
- At least 2 servings
 - At least 3 servings
 - At least 4 servings
 - At least 5 servings
 - Don't know
36. **Which contains the most calories?**
- One gram of protein
 - One gram of fat
 - One gram of carbohydrates
37. **The foods that I eat and drink are healthy so there is no reason for me to make changes.**
- Agree
 - Neither agree nor disagree
 - Disagree
 - Don't know
38. **Not eating breakfast or lunch affects my ability to do well at work.**
- Agree
 - Neither agree nor disagree
 - Disagree
 - Don't know
39. **I think that learning about the connection between food and health is important for people my age to know.**
- Agree
 - Neither agree nor disagree
 - Disagree
 - Don't know
40. **I like to try new foods.**
- Almost always or always
 - Sometimes
 - Almost never or never
41. **How many cups of coffee, caffeinated tea, cappuccino or espresso do you have a week?**
 _____ cups
42. **How many cups of caffeinated soft drinks (for example, Coke® or Pepsi® or other cola) do you have a week?**
 _____ cups
43. **How many cups of hot chocolate do you have a week?**
 _____ cups
44. **How often do you eat dinner with at least one person during a typical week?**
- 0-1 times
 - 2-3 times
 - 4-5 times
 - 6-7 times
45. **How often do you eat fatty fish (salmon, mackerel, herring, lake trout, sardines or albacore tuna) per week?**
- Do not
 - 1-2 times
 - 3-6 times
 - Once a day
46. **How often do you take an Omega-3 supplement (omega oil capsule, fish oil, flax seed or oil) per week?**
- Do not
 - 1-2 times
 - 3-6 times
 - Once a day



Sleep



1) During the past month, what time have you usually gone to bed at night on weekdays and weekends?
Bed time (weekday) _____ **Bed time (weekend)** _____

2) During the past month, how long (in minutes) has it usually taken you to fall asleep each night on weekdays and weekends?
Minutes (weekday) _____ **Minutes (weekend)** _____

3) During the past month, what time have you usually gotten up in the morning on weekdays and weekends?
Wake up time (weekday) _____ **Wake up time (weekend)** _____

4) During the past month, how many hours of actual sleep did you get at night on weekdays and weekends?
(This may be different than the number of hours you spent in bed.)
Hours of sleep per night (weekday) _____ **Hours of sleep per night (weekend)** _____

5) During the past month, how well have you slept on weekdays and weekends?

Weekday	<input type="checkbox"/> Very good	<input type="checkbox"/> Fairly good	<input type="checkbox"/> Fairly bad	<input type="checkbox"/> Very bad
Weekend	<input type="checkbox"/> Very good	<input type="checkbox"/> Fairly good	<input type="checkbox"/> Fairly bad	<input type="checkbox"/> Very bad

6) During the past month, how often have you taken medicine to help you sleep?

<input type="checkbox"/> Not during the past month	<input type="checkbox"/> Less than once a week	<input type="checkbox"/> Never
<input type="checkbox"/> Once or twice a week	<input type="checkbox"/> Three or more times a week	

7) During the past month, how often have you had trouble sleeping because you:

	Not during the past month	Less than once a week	Once or twice a week	Three or more times a week	Do these days include weekends
a. Could not get to sleep within 30 minutes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Woke up in the middle of the night or early morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Had to get up to use the bathroom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Could not breathe comfortably	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Coughed or snored loudly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Felt too cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. Felt too hot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
h. Had bad dreams	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
i. Had pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
j. Other reason(s), please describe:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No

8) During the past month, how often have you had trouble staying awake while in school, while eating meals, or while being with friends?
 Not during the past month Less than once a week Once or twice a week Three or more times a week

9) During the past month, how much of a problem has it been for you to keep up enough energy to get things done on weekdays and weekends?

Weekdays	<input type="checkbox"/> No problem at all	<input type="checkbox"/> Slight problem	<input type="checkbox"/> A noticeable problem	<input type="checkbox"/> A very big problem
Weekends	<input type="checkbox"/> No problem at all	<input type="checkbox"/> Slight problem	<input type="checkbox"/> A noticeable problem	<input type="checkbox"/> A very big problem

10) Ask someone you live with how often, in the past month, you have had:

	Not during the past month	Less than once a week	Once or twice a week	Three or more times a week	Do these days include weekends
a. Loud snoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Long pauses between breaths while asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Legs twitching or jerking while you sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Episodes of sleepwalking or have woken up not knowing where you are	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Other restlessness while asleep, please describe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No



Heart
NIAGARA
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Physical Activity & SEDENTARY PURSUITS

- On how many of the past 7 days did you exercise or take part in physical activity that made your heart beat fast and made you breathe hard for “at least 20 minutes”?**
(For example: basketball, soccer, running, rugby, jogging, fast dancing, swimming laps, tennis, fast bicycling, or similar aerobic activities)
 0 days 1 day 2 days 3 days 4 days 5 days 6 days 7 days
- On how many of the past 7 days did you take part in physical activity or exercise for “at least 30 minutes” where your heart “did not” beat fast or you did not breathe hard, such as fast walking, slow bicycling, skating, pushing a lawn mower, or mopping floors?**
 0 days 1 day 2 days 3 days 4 days 5 days 6 days 7 days
- On how many of the past 7 days did you do exercises to strengthen or tone your muscles, such as push-ups, sit-ups, or weight lifting?**
 0 days 1 day 2 days 3 days 4 days 5 days 6 days 7 days
- In one week, how many days do you go to physical education (PE) or gym class?**
 0 days 1 day 2 days 3 days 4 days 5 days
- During an average physical education (PE) class, how many minutes do you spend actually exercising or playing sports?**
 I do not take PE less than 10 minutes 10-20 minutes 21-30 minutes
 31-40 minutes 41-50 minutes 51-60 minutes More than 60 min.
- During the past 12 months, on how many sports teams (like a community team, summer league, school or church team) did you play?**
For example: soccer, basketball, baseball, rugby, swimming, gymnastics, wrestling, track, football, tennis, and volleyball.
 0 teams 1 team 2 teams 3 teams or more
- Do you participate in any other organized physical activities or take lessons, such as martial arts, dance, gymnastics or fitness class?**
 Yes No
- How many hours per day do you usually watch TV or video movies away from school?**
 0 hours 3 hours
 less than 1 hour 4 hours
 1 hour 5 hours
 2 hours 6 hours or more
- How many hours per day do you usually spend on the computer away from school?**
(Time on the computer includes time spent surfing the internet and instant messaging, as well as doing homework).
 0 hours 3 hours
 less than 1 hour 4 hours
 1 hour 5 hours
 2 hours 6 hours or more
- How many hours per day do you usually spend playing video games like Nintendo®, Sega®, PlayStation®, Xbox®, GameBoy® or arcade games away from school?**
 0 hours 3 hours
 less than 1 hour 4 hours
 1 hour 5 hours
 2 hours 6 hours or more
- I think that learning about the connection between physical activity and health is important for students my age to know.**
 True False

