Fasting Form

FORM CODE: FTR
VERSION B 10/07/2005

ID NUMBER: [ ][ ][ ][ ][ ][ ][ ] CONTACT YEAR: [0][6]

LAST NAME: [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ] INITIALS: [ ][ ]

INSTRUCTIONS: This form should be completed during the participant's visit. ID Number, Contact Year, and Name must be entered above. Whenever numerical responses are required, enter the number so that the last digit appears in the rightmost box. Enter leading zeroes where necessary to fill all boxes. If a number is entered incorrectly, mark through the incorrect entry with an "X". Code the correct entry clearly above the incorrect entry. For "multiple choice" and "yes/no" type questions, circle the letter corresponding to the most appropriate response. If a letter is circled incorrectly, mark through it with an "X" and circle the correct response.

1. Date of clinic visit: .... [ ][ ] / [ ][ ] / [ ][ ][ ][ ]
m m d d y y y y

2. Date of fasting determination: .... [ ][ ] / [ ][ ] / [ ][ ][ ][ ]
m m d d y y y y

3a. Time:... [ ][ ][ ][ ]
h h m m

4. When was the last time you ate or drank anything except water?

4a. Day last consumed: ....

Today	1
Yesterday	2
Before Yesterday	3
Don't Know	7
Refused	8
Missing	9

4b. Time last consumed: ………………. [| | |] h h m m

5. Computed fasting time: …………………………………………………………….…. [| | |] h h m m

6. Have you given blood within the last 7 days? ……………………………….. Yes 1

No 2

Don't Know 7

Refused 8

Missing 9

7. Method of data collection: . ... Computer 1

Paper form 2

8. Data Collected:...In house 1

Off Site 2

9. Code number of person completing this form: ………………..….……………. [| |]