



The CARB Study: Carbohydrates and Related Biomarkers Study Screening Questionnaire

Thank you for your interest in the CARB Study. We need your responses to this questionnaire to make sure that you meet the study rules. There are no right or wrong answers so please answer each question to the best of your knowledge.

Before you begin the questionnaire, find your height and weight on the Body Mass Index (BMI) Table (see next page). If you fit into one of the study weight groups, you may be eligible to join the study.

Completing this screening questionnaire is voluntary and any information you give us will be kept confidential. Your responses will determine if you are eligible to go on to the next step of the study.

Please consider the following list of everyday habits and medical treatments that could affect the study results. You will not be able to take part in the study if you:

- are younger than 18 years of age or older than 45 years of age.
- do not fit into one of the study weight groups (see next page).
- take prescription medications every day (this includes women taking birth-control pills, shots, patch or IUD with hormones)*.
- have been diagnosed with or treated for cancer within the previous five years (except those with a diagnosis and/or treatment of non-melanomatous skin cancer are eligible)
- are currently pregnant or breastfeeding or planning a pregnancy in the next 3 months.
- use any tobacco products on a daily basis (cigarettes, pipes, cigars, chewing tobacco).
- use recreational drugs
- drink the following amount of alcohol almost every day: *2 or more cans/bottles of beer OR 2 or more glasses of wine OR 3 or more ounces of hard liquor.*

PLEASE NOTE: YOU MAY NOT USE ANY TOBACCO PRODUCTS, NUTRITIONAL SUPPLEMENTS including VITAMINS, MEDICATIONS* OR ALCOHOL DURING THE FEEDING STUDY.

If **any** of the above conditions are true, you unfortunately cannot participate in the study. Please do not complete or return this questionnaire. Thank you for your time and interest in helping us

If **none** of the above conditions are true for you, please continue with this questionnaire on the next page.

*Over the counter medications may be allowed, on an occasional basis.

BODY MASS INDEX TABLE

Find your height and weight range on the table. If your Body Mass Index (BMI) falls *between 19 and 25* or *between 28 and 40*, you fit into a study weight group. If you are interested in joining the CARB study, please complete the screening questionnaire. If you do not fit into either of these weight groups, we are sorry but you are not eligible to join the CARB Study. Thank you for your interest in our study.

STEP 1: FIND YOUR HEIGHT IN THE LEFT-HAND COLUMN.

STEP 2: MOVE TO THE RIGHT TO FIND THE YOUR WEIGHT RANGE.

STEP 3: CHECK COLUMN HEADING TO SEE IF YOU FIT INTO ONE OF THE STUDY WEIGHT GROUPS.

	Not eligible if your weight is below	Eligible if your weight is between		Not eligible if your weight is between		Eligible if your weight is between		Not eligible if your weight is above
BMI (kg/m ²)	19	19 and above	Below 25	25 and above	Below 28	28 and above	Below 40	40
Height (in.)	Body Weight (pounds)							
58	90	91	118	119	133	134	190	191
59	93	94	123	124	137	138	197	198
60	96	97	127	128	142	143	203	204
61	99	100	131	132	147	148	210	211
62	103	104	135	136	152	153	217	218
63	106	107	140	141	157	158	224	225
64	109	110	144	145	162	163	231	232
65	113	114	149	150	167	168	239	240
66	117	118	154	155	172	173	246	247
67	120	121	158	159	177	178	254	255
68	124	125	163	164	183	184	261	262
69	127	128	168	169	188	189	269	270
70	131	132	173	174	194	195	277	278
71	135	136	178	179	199	200	285	286
72	139	140	183	184	205	206	293	294
73	143	144	188	189	211	212	301	302
74	147	148	193	194	217	218	310	311
75	151	152	199	200	223	224	318	319
76	155	156	204	205	229	230	327	328

TODAY'S DATE: _____ (ID NUMBER: _____)
To be assigned by study

NAME: _____
(Mr./Mrs./Ms./Miss) First MI Last

MAILING ADDRESS: _____
Street

CITY: _____ STATE: WA ZIP: _____

TELEPHONE CONTACT INFORMATION

	DO NOT to call	OK TO call	MAY WE LEAVE PERSONAL INFORMATION AT THIS PHONE NUMBER?	
			NO	YES
HOME: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
WORK: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CELL PHONE: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The best time to call you is (specify time) _____
at which phone number? Home Work Cell phone

E-MAIL ADDRESS: _____

You can choose to continue to receive information from us by regular mail or change to email. Please remember that some of the information we send may be personal. Information sent by US postal service mail will give you the most privacy.

_____ Continue to send information by U.S. postal service mail
_____ Change to email

HOW DID YOU HEAR ABOUT THE STUDY?

- Enrolled participant
- Letter/email
- Radio
- Public event/fair
- Flyer/Poster
- Newspaper
- TV
- Unknown
- Friend/Relative
- Newsletter
- Class/Meeting
- Other _____

ID NUMBER _____

For the following questions, please check the appropriate box or enter the information requested

1. Date of Birth: ___ ___ / ___ ___ / ___ ___

2. Sex: Male _____ Female _____

3. Height: Feet _____ inches _____

4. Weight: _____ pounds

5. Would you describe yourself as Hispanic or Latino?

- NO
- YES
- Unknown

6. Which of the following best describes your racial and/or ethnic origin (pick all that apply):

- American Indian/Alaskan Native
- Asian
- Black or African American
- Caucasian
- Native Hawaiian or other Pacific Islander
- Unknown

7. Have you gained or lost more than 10 pounds in the last two months?

- NO
- YES

8. Are you on any type of special diet?

- NO. Go to the next question.
- YES

If yes, please indicate below the type of diet you are on:

- Vegetarian
- Vegan
- No red meat
- No dairy products
- Atkins or any other low carb diet
- Gluten Free
- Diabetic or renal diet
- Weight loss
- Other: _____

9. Do you have any food allergies or food intolerances?

- NO (go to next question)
- YES. Please list those foods here.

10. Are there any foods or beverages that you strongly dislike and will not eat?

- NO (go to next question)
- YES. Please list those foods or beverages here.

11. Please indicate how often you usually eat the following meals and snacks. Place an "x" in the box for the meals and snacks you usually eat.

Day of week	Meals and Snacks					
	Breakfast	Lunch	Dinner	1-2 snacks	3-4 snacks	5+ snacks
Monday						
Tuesday						
Wednesday						
Thursday						
Friday						
Saturday						
Sunday						

12. Please answer the following questions:

NO YES

Do you make yourself sick because you feel uncomfortably full?		
Do you worry you have lost control over how much you eat?		
Have you recently lost more than 17 pounds in a 3 month period?		
Do you believe yourself to be fat when others say you are too thin?		
Would you say that food dominates your life?		

13. Do you take any dietary supplements including: multi-vitamins, individual vitamin/mineral supplements, protein powders, herbal supplements or other special supplements like glucosamine?,

- NO. Go to the next question
- YES

If yes, would you be willing to stop your supplements and not start any new supplements for the duration of the study? This would begin one week before and continue through each feeding period.

- NO
- YES

17. Has a doctor ever told you that you had any of the following?

Please check yes or no for each question:

NO

YES

Liver Disease, elevated liver enzymes or Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes or high blood sugar	<input type="checkbox"/>	<input type="checkbox"/>
Clotting abnormalities	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diseases of the GI tract including Crohn's, Ulcerative Colitis, Inflammatory Bowel Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diverticulitis	<input type="checkbox"/>	<input type="checkbox"/>

18. For women: Have you been pregnant or nursing during the past 3 months?

NO

YES

19. Are you currently being treated by a doctor for any disease or medical problems?

NO. Go to the next question

YES

If yes, please list each treated disease or medical problem(s), date of diagnosis and any medications you are currently using.

Disease/Medical Problem Date Of Diagnosis Medications (if any)

20. To be part of this study, you must eat dinner at the Human Nutrition Lab, Monday through Friday evenings. Are there any evenings when your schedule would prevent you from eating dinner at the Human Nutrition Lab? (ie classes, work, sports, meetings)?
Note – evening commitments do not exclude you from the study; we ask this information to help scheduling.

NO

YES

If yes, please tell us how often (per week or month) and which days.

21. Will you be living in the Seattle area for the next 16 weeks (the approximate amount of time it will take to complete the screening steps and the study)

NO

YES.

22. May we contact you about other studies related to diet and their influence on cancer biomarkers?

- NO**
 YES

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE.

Please place the completed questionnaire in the envelope provided or send to:

*The CARB Study, M4-B402
PO Box 19024,
Seattle WA 98109-1024.*

We will contact you soon about your study eligibility.