1. Date of clinic visit 3:
   / / 
   month day year

2. Date of fasting determination:
   / / 
   month day year

3.a. Time: 
   h h m

3.b. AM .................. A
     PM .................. P

4. When was the last time you ate or drank anything except water?
   a. Day last consumed: ........ Today T
      Yesterday Y
      Before Yesterday B

4.b. Time last consumed: 
   h h m

   c. AM .................. A
      PM .................. P

5. Computed fasting time: ........... __ __ hours

6. Have you given blood within the last 7 days? .............. Yes Y
   No N

7. Method of data collection ....... Computer C
   Paper P

8. Code number of person completing this form: ...........