Fasting Form

ID NUMBER: __________________________ CONTACT YEAR: _________

LAST NAME: __________________________ INITIALS: __________

INSTRUCTIONS: This form is to be completed during the participant’s clinic 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: ______________ 3b. AM A
    h h m m
    PM P

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

4a. Day last consumed: __________________________ Today T
    Yesterday Y
    Before Yesterday B

4b. Time last consumed: __________
   h h m m

5. Computed fasting time: __________________________
   __________________________ hours

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

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

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