

NUTRITIONAL OUTCOME SURVEY

Version: January 30, 2001

Last Name: _____ First Name: _____

Date of Birth: _____ Gender: Male Female

We are conducting a nutrition survey with people like you to find out how we can better meet the needs of older adults. We would appreciate it if you would answer the following questions. Your answers will be strictly confidential and will not affect the services that you are receiving in any way.

Please answer each question by circling only one response category:

1. How many meals do you eat per day? 0 1 2 3 or more
2. How many meals do you eat alone in a day? 0 1 2 3 or more
3. How many servings of fruits do you eat per day? 0 1 2 3 or more
4. How many servings of vegetables do you eat per day? 0 1 2 3 or more
5. How many servings of whole or enriched bread, cereal, rice, pasta, noodles, or tortillas do you eat per day? 0 1 2 3 4 5 6 or more
6. How many servings of milk, cheese, yogurt, or calcium rich soy products do you eat per day? 0 1 2 3 or more
7. How many servings of high protein food do you eat per day, such as meat, poultry, tofu, fish, beans, peas, eggs, or nuts? 0 1 2 3 or more
8. How many drinks of beer, liquor, or wine do you have almost every day? 0 1 2 3 or more
9. How many glasses of water or other non-alcoholic fluids do you drink per day? 0 1 2 3 4 5 6 7 8 or more
10. Have you gained 10 pounds or more in the last 6 months without trying? YES NO
- If YES, have you seen a doctor or other professional about your weight gain?^{10B} YES NO

OFFICE USE ONLY

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Client ID: _____ Survey Date: _____ Program: HDM CM Other
Test was: Self-administered In-person Interview Phone Interview Mail Don't know Other _____
Questionnaire was filled out by Proxy? Yes No Don't know

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| 11. Have you lost 10 pounds or more in the last 6 months without trying? | YES | NO |
| If YES, have you seen a doctor or other professional about your weight loss? _{11B} | YES | NO |
| 12. Do you have an illness or condition that made you change the kind and/or amount of food you can eat? | YES | NO |
| If YES, have you received information to help you make the necessary food changes? _{12B} | YES | NO |
| 13. Do you have tooth or mouth problems that make it hard for you to eat? | YES | NO |
| 14. Do you take 3 or more different prescribed or over-the-counter drugs a day? | YES | NO |
| 15. Are you physically able to shop for yourself? | YES | NO |
| If NO, do you have someone who can shop for you? _{15B} | YES | NO |
| 16. Are you physically able to cook for yourself? | YES | NO |
| If NO, do you have someone who can cook for you? _{16B} | YES | NO |
| 17. Are you physically able to feed yourself? | YES | NO |
| If NO, do you have someone who can help you? _{17B} | YES | NO |
| 18. Do you always have enough money or food stamps to buy the food you need? | YES | NO |