

January 1, 2007

Dear Teens and Parents,

Enclosed in this packet you will find the screening questionnaire for 2007 Camp Calcium which will take place June 13 – July 3 and July 11- August 1. Please fill this form out together to ensure the most accurate information possible. Since this questionnaire does ask for sensitive information we ask that a parent or guardian please sign the bottom of the first page giving permission to the teen to complete the questionnaire and apply for this camp experience.

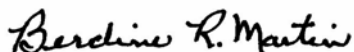
After completing the questionnaire, please return it to us in the enclosed envelope. We will use this information to determine if the teen is eligible. You will then receive notice of eligibility and an invitation to attend an informational meeting where you will receive more details about the camp. At this meeting we will also ask both parents and teens to sign a consent form to participate in the camp as well as other required forms. We will try to schedule meetings in various areas of the state to minimize travel.

Registration fee (\$100) will be due on the first day of camp unless other arrangements are made. Teens will be reimbursed at the end of each three week period (\$210/3 week period).

We are looking forward to this summer experience and the chance to get to know all of you. We appreciate your willingness to help us answer a very important research question.

If you have any questions please feel free to contact me by phone or e-mail.

Sincerely,



Berdine R. Martin
Senior Research Associate, Camp Director

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SCREENING INSTRUMENT
Calcium and Vitamin D in Adolescent Girls

1. Date _____

Name _____
 First Middle Last

Local Address _____
 Street Apt.

 City State Zip

Phone (____) _____ E-mail: _____
 Home

2. Date of Birth _____ , _____
 month day year

3. Age _____

4. Height _____ (ft, in)

5. Weight _____ (lb)

6. Race of biological mother:
 ___ Asian
 ___ African American
 ___ Hispanic
 ___ White

Race of biological father:
 ___ Asian
 ___ African American
 ___ Hispanic
 ___ White

Race of biological maternal grandmother:
 ___ Asian
 ___ African American
 ___ Hispanic
 ___ White

Race of biological maternal grandfather:
 ___ Asian
 ___ African American
 ___ Hispanic
 ___ White

Race of biological paternal grandmother:
 ___ Asian
 ___ African American
 ___ Hispanic
 ___ White

Race of biological paternal grandfather:
 ___ Asian
 ___ African American
 ___ Hispanic
 ___ White

7. If a doctor has ever told you that you had any of the following conditions, please check and list the year when this occurred.

<u>Condition</u>	<u>Year</u>
<input type="checkbox"/> Sickle Cell Anemia	_____
<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Heart Disease	_____
<input type="checkbox"/> Hypertension	_____
<input type="checkbox"/> Atherosclerosis	_____
<input type="checkbox"/> Chronic Bronchitis	_____
<input type="checkbox"/> Asthma	_____
<input type="checkbox"/> Hay Fever	_____
<input type="checkbox"/> Tuberculosis	_____
<input type="checkbox"/> Hepatitis	_____
<input type="checkbox"/> Liver Disease (cirrhosis)	_____
<input type="checkbox"/> Malaria	_____
<input type="checkbox"/> Cancer	_____
<input type="checkbox"/> Epilepsy	_____
<input type="checkbox"/> Thyroid Condition	_____
<input type="checkbox"/> Stomach Ulcers	_____
<input type="checkbox"/> Bladder Disease	_____
<input type="checkbox"/> Kidney Disease	_____
<input type="checkbox"/> Crohn's Disease	_____
<input type="checkbox"/> Chronic Colitis	_____
<input type="checkbox"/> Diverticulosis	_____
<input type="checkbox"/> Rheumatoid Arthritis	_____
<input type="checkbox"/> Leukemia	_____
<input type="checkbox"/> HIV	_____

8. Have you had any other major illness? Yes No

If yes, please list them and the year you had them.

<u>Illness</u>	<u>Year</u>
_____	_____

9. Have you ever had bone fractures? Yes No

If yes, please specify which bone and how old you were.

<u>Bone</u>	<u>Age of occurrence</u>
_____	_____

10. Do you have any allergies? Yes No

If yes, please specify _____

BECAUSE CALCIUM METABOLISM IS CLOSELY RELATED TO STAGE OF PHYSICAL DEVELOPMENT WE MUST ASK THE FOLLOWING QUESTIONS. PLEASE ANSWER THEM AS ACCURATELY AS POSSIBLE.

11. Have you started having menses? Yes No
If yes, when did you start? Date _____
Month Year

IF NO, SKIP TO QUESTION NUMBER 21

12. How many menstrual cycles have you had in the last year? _____

13. Length of cycle? _____ Days (How many days between the beginning of one period and the beginning of your next period?)

14. Length of period? (How many days do you bleed?) _____

15. When did your last regular period begin? _____

16. Have you ever been pregnant? Yes No
If yes, when were you last pregnant (date) _____?

Number of pregnancies _____ Number of live births _____

17. Are you currently under a physician's care for amenorrhea (cessation of periods) or in the past have you been amenorrheic? Yes No

18. Are you currently using any form of contraceptives?
 Yes No

If yes, what is the name of the contraceptive? _____
What is the dosage? __high__medium__low __don't know

If you are not currently using contraceptives, have you used them in the past?

Yes No

PLEASE TELL US ABOUT ANY MEDICATIONS YOU MAY BE TAKING

19. Do you take any prescription or non-prescription medications regularly?
___ Yes ___ No

If yes, indicate the name of the medication and how long you have been taking it.

20. Medication/Dose _____ When did you start taking it?

21. Do you take antacids regularly? ___ Yes ___ No

If yes, how often? _____

22. If yes, what is the name of the antacid?
Circle the correct preparation.

- 1. Tums or Chooz 5. Mylanta, Maalox, Digel or Gelusil
- 2. Tritalac 6. Rolaid
- 3. Alkamints 7. Other
- 4. Gas-X

23. Describe your cigarette smoking habits
___ currently smoke
___ smoked in past, but not now
___ seldom or never smoked cigarettes

24. If smoking now, how many cigarettes do you typically smoke during a 24-hr day? _____

25. How frequently do you have bowel movements?
2 or more times a day ___ Every 2 days ___ Every 5 days ___
1 time a day ___ Every 3 days ___ Every 6 days ___
Every other day ___ Every 4 days ___ Every 7 days ___

PHYSICAL ACTIVITY EVALUATION

1. List 3 ways you spend your time outside of school activities.

2. Are you currently working? Yes No
If yes, what is your job? _____

3. Describe your current level of physical activity by checking the appropriate column to indicate the number of times per week or month or year that you participate in each activity. Check only one box for each physical activity.

		Times/Week				Times/Month	Times/year
		Never or rarely	Every day	1-2	3-4	5-6	1-3
Running or jogging							
Hiking or outdoor walking							
Riding a bicycle							
Swimming (laps)							
Tennis, racquetball, handball, basketball							
Weightlifting							
Golf							
Aerobics							
Other (please list)							

4. How much time do you usually spend each time you exercise?

Less than 10 minutes

11-20 minutes

21-30 minutes

31-40 minutes

41-50 minutes

more than 50 minutes

5. How many hours sleep do you usually get during a 24 hour day?

Less than 4 hours

5-6 hours

7-8 hours

9-10 hours

11 hours or more

NUTRITION INFORMATION

1. How many meals do you usually eat per day? _____
2. How many snacks do you usually eat per day? _____
3. How many times on the average do you eat in restaurants per week?
Please circle one choice for each meal or snack.

BREAKFAST	None	1	2	3	4	5	6	7
AM SNACK	None	1	2	3	4	5	6	7
LUNCH	None	1	2	3	4	5	6	7
PM SNACK	None	1	2	3	4	5	6	7
DINNER	None	1	2	3	4	5	6	7
EVENING SNACK	None	1	2	3	4	5	6	7

4. Of the meals you eat in restaurants how many fast food meals do you eat per week (i.e., hamburgers, fried chicken, tacos, etc.) _____
5. Are you currently on any of the following special diets?
(more than one diet may apply)

A. <input type="checkbox"/> None	D. <input type="checkbox"/> Low Salt
B. <input type="checkbox"/> Weight Loss	E. <input type="checkbox"/> Low Cholesterol
C. <input type="checkbox"/> Vegetarian (do not eat meat but do eat eggs & milk)	F. <input type="checkbox"/> Weight Gain
	G. <input type="checkbox"/> Low Calcium

6. Do you have an allergy to milk?
7. Are you considered to be lactose or milk intolerant? Yes No
8. Do you take calcium supplements? Yes No
9. If yes, what is the name of the supplement? _____
How much calcium does it contain per tablet? _____ mg
How many tablets do you take per day? _____
10. Do you take a multivitamin/mineral supplement? Yes No
If yes, what is the brand name? _____
How much calcium does it contain? None _____ mg don't know

11. Do you use any of these products? If yes, please fill in the following.

PRODUCT	AMOUNT (mg)	TIMES/DAY	BRAND
Vitamin C			
Vitamin E			
Vitamin A			
Vitamin B-12			
Vitamin B-6			
Iron			
Zinc			
Magnesium			
Selenium			
Bran			
Wheat germ			
Brewer's yeast			
Cod liver oil			
Weight loss pills			
Weight loss formulas			
Other (please list)			

12. How much water do you usually drink per day?
___ Seldom drink water ___ 1-2 cups/day ___ 3-5 cups/day ___ 6+ cups/day

13. Which foods will you refuse to eat?

14. Which foods do you eat almost everyday?

