To the Graduate Council:

I am submitting herewith a dissertation written by Cecilia Watkins entitled "A Comparative Study of Health Risk Profile Results Between Seventh Day-Adventist College Students and Public College Students." I have examined the final copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the of Doctor of Philosophy, with a major in Human Ecology.

Robert J. Pursley, Major Professor

We have read this dissertation
And recommend its acceptance:

Accepted for the Council:

Associate Vice Chancellor and
Dean of The Graduate School

A COMPARATIVE STUDY OF HEALTH RISK PROFILE RESULTS BETWEEN SEVENTH-DAY ADVENTIST COLLEGE STUDENTS AND PUBLIC COLLEGE STUDENTS

A DISSERTATION PRESENTED

FOR THE DOCTOR OF PHILOSOPHY DEGREE

THE UNIVERSITY OF TENNESSEE, KNOXVILLE

CECILIA MICHELLE WATKINS

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DEDICATION

This dissertation is dedicated to my grandparents, E.N. and Virginia Vincent. Without their love and support, I could never have accomplished this goal. Gone, but never forgotten. Also, my son, Chris and my daughter, Cari, who loved and believed in me through the good times and the bad. You give me strength. I will love you always.

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ABSTRACT

The purpose of this study was to compare the health profile results of Seventh-day Adventist College students with the health profile results of State University students in the southern region of the United States. The instrument used in this study was the Eris Personal Risk Analysis questionnaire.

The Seventh-day Adventists were chosen to be a part of this study due to their strict adherence to a healthy lifestyle. The State University students were chosen to be a part of this study as a sample of the average college population.

The specific health risks compared in this study were Wellness Now Scores, rate of overweight/obesity, mean aortic blood pressure, smoking score, alcohol consumption, and life satisfaction. The findings concluded that the Seventh-day Adventist scored significantly healthier in Wellness Now Scores, smoking score and alcohol consumption. These findings support the ideology that healthy lifestyles and health status are closely linked and that prevention is the best health care practice.

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CHAPTER I

INTRODUCTION

The primary objective of this chapter was to examine the necessity and establish the parameters of this study. The chapter addresses the rationale of prevention in health behavior and also how awareness, through health risks appraisals, can promote positive lifestyle habits.

Healthy lifestyles are the first step toward the prevention of disease and premature death. The major causes of death in the United States today are chronic diseases such as heart disease, cancer and stroke. Behavioral factors, especially tobacco use, diet and activity patterns, alcohol consumption, sexual behavior and avoidable injuries are among the most prominent contributors to mortality (Glanz, 1997). Since the 1960s and 1970s many chronic diseases once thought to be an inevitable result of aging have been reclassified as avoidable. A 1994 assessment by the Center for Disease Control and Prevention (CDC) estimated that nearly forty-seven percent of premature deaths of Americans could have been avoided by changes in individual behaviors (Healthy People 2000).

Healthy lifestyles have been part of the Seventh-day Adventists doctrine since the mid-19th century. Practices such as the use of tobacco, caffeine, alcohol, illicit substances, and products derived from scavenger animals (pork, shellfish, etc.) are discouraged, while lacto-ovo-vegetarian diets, although not required, are strongly encouraged. The use of pure water (internally and externally), the consumption of a wide variety of fruits, vegetables, whole grains, nuts, and low-fat dairy products; daily exercise; and fresh air and sunshine are all recommended practices of the Seventh-day Adventists. Seventh-day Adventists who follow these doctrines may practice a healthier lifestyle than the average American does (Murphy, 1997).

The results of a health profile report of Seventh-day Adventist should be statistically superior when compared to the national average. With these data the opinion may be embraced of the importance that lifestyle behaviors have on health, not only for individuals, but also for the nation as rising health costs threaten an ever delicate economic system.

Health education and health promotion are two vehicles used to increase an individual's awareness about one's health behavior. Health education has been defined by the Role Delineation Project as "the process of assisting individuals, acting separately or collectively, to make informed decisions about matters affecting their personal health and that of others." Health promotion is "any combination of health education and related organizational, economic, and environmental supports for behavior of individuals, groups, or communities conducive to health". Positive informed changes of health behavior is the main concern of both health education and health promotion (Glanz, 1997).

A tool used to increase awareness and subsequently increase positive health behavior is the health risk appraisal (HRA). HRAs are also used to capture the attention of persons whose understanding of risk and the potential of its reduction may be improved through the graphic presentation of the individual's health risk profile based on epidemiological data for persons of their same age, race and gender (DeFriese, 1987). Through application of the HRAs, individuals can increase their

knowledge of specific health risks, which can influence their ability to acquire optimum health.

College students are one group that health professionals have not devoted a significant amount of time to research the benefits of HRAs. Although college students are perceived as young and healthy, in reality, today's college students are often older and experience many chronic medical problems. Students in the most common age category (17-25 years old) have the least overall reduction in morbidity and mortality rates, according to national health indicators.

HRAs could provide health benefits for both younger and older students. The stress that all students experience during college life contributes to the many emotional and physical challenges common in the college population (Hyner, Peterson, Travis, Dewey, Foerster, Framer, 1999).

PURPOSE OF THE STUDY

The purpose of this study was to compare the health profile results of Seventh-day Adventist College students with the

health profile results of State University students in the southern region of the United States.

RESEARCH QUESTIONS

In order to address the purpose, the following research questions were formulated:

1. What were the differences between the Wellness Now scores of Seventh-day Adventist College and State University students?

2. What were the differences between the average rate of overweight/obesity of the Seventh-day Adventist College and State University students?

3. What were the differences between the average mean aortic blood pressure of the Seventh-day Adventist College and the State University students?

4. What were the differences between the average smoking score of the Seventh-day Adventist College and the State University students?

5. What were the differences between the average alcohol consumption score of the Seventh-day Adventist College and the State University students?

6. What were the differences between average satisfaction of life score, as measured by the Personal Risk Analysis, of the Seventh-day Adventist College and State University students?

NEED FOR THE STUDY

Health, United States 1998 states that death due to chronic disease now account for nearly three-fourths of all deaths of persons ages 25-64. Cardiovascular diseases, cancer, and diabetes, combined account for over $300 billion in direct medical costs each year. Chronic diseases are often the consequences of poor health behaviors. Many health behaviors are influenced by social factors, which are instilled in childhood, or associated with a particular culture, socioeconomic or peer group (Patterson, 1992).

The relationship between health behavior and chronic diseases must be reinforced to further emphasize the importance of prevention. Prevention is the best defense to prevent chronic diseases. The correlation between behavior and disease must be continually kept in the forefront of the nation's health agenda. Only then will positive action on the part of the government make prevention a priority, which can make a significant difference in advancing our nation's health.

A healthy lifestyle should lead to a healthy life, free from chronic disease. The positive health behaviors of the Seventh-day Adventist should support this correlation of lifestyle and disease. An analysis of Seventh-day Adventist College students and State University student's personal health behaviors has the potential to increase the link between lifestyle habits and health. The personal health risk analysis of the Seventh-day Adventists should reveal the impact that positive health habits can have on health.

The Theory of Reasoned Action (TRA) focuses on reasons why individuals display specific behavior. This theory is concerned with the relations between beliefs, attitudes,

intentions, and behavior. Attitudes concerning the characteristics of an action or behavior determine the expectations or beliefs toward performing that action or behavior (Glanz, 1997). This theory would help this study to explore the motivation behind certain group's behaviors and beliefs and allow certain assumptions to be made.

In this day of modern technology, the computer is the quickest and most reliable way to retrieve data. Computerized Health Risk Appraisals (HRAs) have proven to be a fast and painless way to raise awareness among individuals about their health status. Through a health risks appraisal, the areas with the highest risks can be identified and attention focused on those risks (Gillis, 1994). Awareness fosters positive behavior change, which in turn cultivates prevention.

HRAs benefits include the fact that they are low cost and user friendly. HRAs are also popular with clients and possibly increase the participation rate in health promotion programs. Preventive health information is organized systematically with the use of HRAs. HRAs emphasize modifiable risk factors and summarizes major health problems. Finally, HRAs possibly increase motivation, which could enhance the likelihood of positive

behavior changes (Hyner, Peterson, Travis, Dewey, Foerster, Framer 1999).

Moreover, the Social Comparison Theory suggests that "our quest to know ourselves", is about the search for self-relevant information and how people gain self-knowledge and discover reality about themselves. The theory implies that individuals are driven by a desire for self-evaluation, a motivation to establish that their opinions are correct and to know precisely what they are capable of doing (Buunk, 1997). With this in mind, awareness would seem to be a desired state in which one thrives to be the best possible.

The positive health habits of the Seventh-day Adventist allow health care professionals the opportunity to capture the statistical data needed to demonstrate that individuals have much more control over their future state of health than many would admit. Only ten percent of the average American, according to a study on lifestyle patterns, had an overall healthy lifestyle (Patterson, 1992). A look at how relevant health habits are in all person's quality of life should affect each individual's personal health plan and the national agenda in how society deals with health care in the 21st Century.

This study was conducted to confirm the link between healthy lifestyles, religion and health status. Religion and health are linked, but the extent of this connection and the mechanisms of effect call for further studies and will not be addressed in this study (Ferraro, K. and Koch, J., 1994). Rather, this comparative analysis was used to address the research questions of this study.

BASIC ASSUMPTIONS

For the purpose of this study it was assumed that:

1. The instrument (HRA) used in this study was valid and reliable.
2. The individuals answered the questions in the HRA honestly.

DELIMITATIONS

This study was delimited to college students in the southern United States.

DEFINITIONS

For the purpose of this study the following definitions were used:

Behavioral factors: Demographic variables (age, gender, race, ethnicity, etc.) and sociopsychological variables (personality, social class, peer and reference group pressure, etc.) which influence an individual's action toward a specific health objective.

Mean Aortic Blood Pressure (MABP): The average difference between systolic and diastolic pressure during the entire cardiac cycle. The mean arterial pressure can be roughly estimated as the diastolic pressure plus one-third of the pulse pressure.

Personal Health Risk Analysis: The measure derived from a health risk appraisal (HRA) revealing the present state of health of an individual and recommendations to improve the state of health, as measured by Eris Survey Systems, Inc.

State University College Students: Students enrolled in a freshman level health class at a public state university.

Seventh day Adventist College Students: Students enrolled in a Seventh-day Adventist College. (SDA) "Adventist" refers to the belief that Jesus is coming soon. "Seventh-

day" means they observe the seventh day of the week as the Sabbath.

Southern region of the United States: The three states of Tennessee, Florida and Texas will be considered this region, with one Seventh-day Adventist College and one State University in each state.

Wellness Now Score: The ratio between the sum of the contribution to risk of dying in the next 10 years, (Your Risk), and the risk factors that do not meet the recommended target level, (Target Risk).
On a scale of 0-100, with 0 being the lowest score possible and 100 being the highest.

SUMMARY

This chapter addressed the need to compare health profile results between Seventh-day Adventist College students and State University students. The Seventh-day Adventists were chosen to be a part of this study due to their strict adherence to a healthy lifestyle. The State University students were chosen to be a part of this study as a sample of the average college population. With the data received as a result of this study a stronger correlation may be established between healthy lifestyle

and positive health risks appraisal results as compared to the average population.

The need for this study was identified through the establishment of health statistics from a healthy population as compared to the average population to identify criteria for prevention against disease and early mortality. The evaluation of the health behaviors of this healthy population could also enhance an innovative prevention program.

The use of HRAs to measure the health of two populations with different lifestyles produces a quantitative approach, which will emphasize the relationship between lifestyles and health.

CHAPTER II

REVIEW OF LITERATURE

INTRODUCTION

The purpose of this chapter was to review the literature that significantly contributed to this study. To enhance the ability of the researcher to conduct a thorough investigation, the literature that was analyzed is presented as it related in content, methodology, and content and methodology.

STUDIES AND LITERATURE RELATED IN CONTENT

Health risk appraisals (HRAs) are used to heighten an individual's awareness of his/her health status. An HRA personalizes relevant health information, which makes it more important and useful to the individual. Appraisals stimulate behavioral change with respect to important health risk factors such as smoking, sedentary lifestyle patterns, dietary behavior and alcohol use. Health risk appraisals have their greatest potential as a tool in helping individuals to easily understand their own personal risk, suggest changes in personal health habits or

behaviors and thus motivates behavior change (DeFriese, 1987).

Health risk appraisals are instruments that assist in the identification of risk factors that affect life expectancy. An HRA consists of three essential elements: An assessment of personal health habits and risk factors based on a questionnaire completed by an individual; a quantitative interpretation of the individual's future risk of illness, disease or death; and educational counseling sessions regarding alternative health behaviors that may decrease the risk of disease or death. The last component of an HRA consists of a computerized report that summarizes the chances of premature death due to individual risk factors. The use of HRAs have been used to encourage individuals in health agendas, build prevention into clinical practice, summarize corporate health problems, and measure general health behavior patterns (Bago, 1996).

Teschler (1987) comments that there are four basic types of HRAs: self-scored HRAs, microcomputer-based HRAs, microcomputer-based and interactive HRAs, and computer-scored and batched-processed HRAs. The most sophisticated type of HRA is the computer-scored and batched-processed form and is the one selected for this study.

The role of HRAs have grown in use due to an increase of health costs which promotes the need to be cost effective, an increase focus on accountability and the individual's responsibility to assess and address health needs. (Gilmore, 1989). HRAs help individuals to establish goals and stay focused on their progress toward achieving those goals.

Due to the extended use of HRAs, health professionals are encouraged to evaluate their effectiveness. HRAs have the potential to enhance communication between the health professional and the client, provide opportunities for continued feedback, and identify sources of information and positive reinforces of healthy behavior change. Along with this opportunity for improved health action comes the potential for harmful assumptions when the HRA is used incorrectly. Uniformed interpretation of results could prove ineffective, even harmful when counseling and follow-up are not included as part of a HRA evaluation (Hyner, 1985).

The University of Wisconsin, Stevens Point was the first college to use HRAs in the development of educational and risk reduction programs to address the health needs of its students. The Lifestyle Assessment Questionnaire, a

health risk appraisal, was used to adapt their wellness program to meet individual needs and concerns (The Society of Prospective Medicine, 1998). The University of Wisconsin, Stevens Point, with their concentration on wellness, has helped to establish the importance of awareness and prevention through HRAs and self-responsibility at the academic level.

STUDIES AND LITERATURE RELATED IN METHODOLOGY

A comparative study was conducted (Taylor, R.J., Chatters, L.M., Jayakody, R. 1996) to examine race differences in religious participation across several national samples. The data came from seven national data sets from the Institute for Social Research, the University of Michigan and the General Social Surveys, collected by the National Opinion Research Center, the University of Chicago. The analysis of these data was limited to black and white respondents.

Each survey contained a measure of religious attendance and denominational affiliation along with other aspects of religious involvement. Several intervening factors (socioeconomic status, region, and religious

affiliation) were controlled. The analysis, using a regression model, verified the presence of consistent racial differences in religious involvement. African-American respondents demonstrated higher levels of both public and private religious behavior than whites.

(Reimer, 1995) conducted a research project comparing measures of religiosity in the U.S. and Canada. The following hypotheses were proposed: levels of orthodox belief and practice will be higher among nonattenders in America than in Canada; there will be a greater difference in levels of orthodox belief and practice between nonattenders and attenders in Canada than in the United states; indicators of religious commitment will be more highly correlated in Canada than in the United states.

Three data sets were used to test these hypotheses. The World Values Survey, the 1988 General Social Survey and the 1990 Project Can90 Survey. The use of Stark and Glock's (1968) measures of commitment, including beliefs, practices and experiences were used to analyze the data. Hypotheses 1, 2 and 3 were supported by significant correlation in the four analyzed data tables. It was also concluded that American culture-religion encourages

religiosity through social convention more so than in Canada.

An important research study was conducted in 1977 by Lee Sigelman, which proved to be one of the few directly comparative analyses across a number of countries. The study analyses cross-national patterns in reported levels of church attendance and selected religious beliefs. This current study (Campbell and Curtis, 1994) revisits the Sigelman study updating the data, including more countries in the study and more measures of religious involvement. Hypotheses include: Americans would be comparatively high on church attendance and subscription to religious beliefs; there would be a widespread international acceptance of belief in God, but fewer general agreements on other religious beliefs.

The data source is the World Value Survey, a cross national study of 22 countries. The survey included questions concerning church attendance, participation in religious voluntary organizations, feeling religious, and belief in the importance of religion for children, and dedication to various religious beliefs.

Multiple classification analysis (MCA) was the technique used in the multivariate controlled comparisons.

This technique examined the relationships between a single categorical independent variable and a continuous dependent variable, while holding constant the control variables. The data used for this study was national patterns without controls, national patterns with control, and 15-year comparisons.

Conclusions show that no great cross-national consensus on being religious, except for the belief in God and different levels within each nation and different cross-national patterns. Belief in heaven, life after death, a soul, and sin has a moderately high level of support across nations, with English-speaking countries placing the highest. Correction factors need to be incorporated into future reports to obtain more credible results.

A comparison study was conducted examining the levels of stress between college students who participate in regular exercise and those who do not. This research (Hanggie, 1996) studies the concept that exercise is an important component in stress management. Based on Physical Exercise Status scores, two groups; Group A, exercisers, (n= 53) and Group B, nonexercisers, (n=48) were chosen as subjects for this study.

The Derogatis Stress Profile assessed stress levels. Subjects listed major stressors they had experienced in the past year. A Chi-square significance test was completed on the most frequently mentioned stressors to compare differences between the two groups. A t-test was done to compare the means of the two independent groups with the dependent variable (perceived level of stress) to ascertain probability and statistical significance of the results. The significance level sought on all tests was $p < .05$.

Pearson's Product Moment correlation was used to compare the selected variable, the amount of exercise. A comparison of the stress scores was correlated with the selected variable of health perception. Higher levels of regular exercise were found to be related to lower stress scores for environmental domain, vocational satisfaction, domestic satisfaction, health posture, emotional response, hostility, subjective stress score and total stress score. Group B had a significantly higher stress scores than Group A. It was concluded that exercise should be incorporated into the college student's educational process.

STUDIES AND LITERATURE RELATED IN CONTENT AND METHODOLOGY

Edna Gillis (1994) conducted a comparative study of the health status of community dwelling elderly living in Eastern Tennessee area using a Health Risk Appraisal. Gillis's study involved similar methods to this study, with the use of an HRA, although due to the different populations studied, and the different HRA instrument, the results would expect to be totally distinct. The instrument that was used in this 1994 study was the health risk appraisal "Healthier Living: An Appraisal Program for Older Americans," developed through the Healthier People Network Inc., Decatur, Ga. A sample of 246 individuals, 60 years or older living in senior homes was randomly selected by the use of a proportional sampling design. The data collected was entered into the EPI-INFO program for analysis. Descriptive research methods and the chi-square test presented the results.

This study concluded that when comparing the health factors of residents of Eastern Tennessee with those health factors found on a national basis, Eastern Tennessee residents rated higher in self perception of health, the

non-use of tobacco and exercise habits and a lower rating in vision and hearing impairment.

Many studies have used populations that are in a self-contained environment. The purpose of the study in (Greek's, 1987) research of Seventh-day Adventist was their well behaviors and identifying motivators in maintaining health-eliciting behaviors. The subjects in the sample were selected from a sampling frame. The sampling frame was the roster of Seventh-day Adventists with membership standing who lived in Georgia, eastern Tennessee and Cherokee County in North Carolina; and who were 18 years of age and older.

Random computerized sampling was conducted from the roster of the adult membership of the Seventh-day Adventist Church. The questionnaire was researcher-developed and included demographic data and three open-ended questions. There was 439 questionnaires mailed out with 135 of those being returned and 106 acceptable for analysis. Content analysis was used to analysis the data.

Conclusions found that the following health habits were practiced in order of importance: proper diet, exercises, avoidance of alcohol, caffeine, or drugs; adequate rest and sleep; and practiced spiritual activities. Health motivations for practicing healthy

lifestyles revealed that most of the Seventh-day Adventist in the study desired good health and followed the Biblical belief that their bodies were the Temple of God, and felt responsible to care for their bodies in an optimum way to glorify God and serve others.

(Ferraro and Koch, 1994) conducted a study that examined the relation between religion and health among African-Americans and white adults. The social support hypothesis states that ties to religious groups may provide "emotional, cognitive and material support, fostering the individual's perception that he or she is cared for and esteemed." This hypothesis is supported by this study.

The data used for this research project were from the Americans' Changing Lives, a national survey of 3,617 people. The study sample was selected under a multistage area probability sample design. The analysis was presented in three tables. Table one included means and standard deviations of variables by race; Table two showed regressions of religiosity on independent variables; Table three presented regressions of health status on independent variables.

One of the major purposes of this paper was to determine if the link between religion and health varies

between whites and African Americans. The social support hypothesis was supported by the findings of this study. The effects of social support on health appear quite similar for African-Americans and whites, despite the higher levels of religious identification and participation among African-Americans. The link between religion and health is stronger for African-Americans than whites when it involves those who practice their religion and reap positive benefits of health. African-Americans in poor health were more likely to turn to religion as a way to cope with the physical challenges.

(Neal, 1992) conducted a study to assess the reliability and validity of a HRA for a college population. The College Wellness Check was the health risk appraisal used in this study, developed by the Rhode Island Health Department. A computerized health risk appraisal questionnaire was used to collect the data. The study included 168 male and female Middle Tennessee State University students. The HRA was used to obtain the descriptive statistics relating to gender, race and percentage of specific health risk factors.

The statistical package SPSSx was used to determine the Pearson Product-Moment Correlation Coefficient for the

reliability test-retest. To validate the survey questionnaire, it was sent to a jury of thirty health professionals. Twenty-one of the thirty health professionals returned the survey questionnaire. A percentage of agreement method was used to determine content validity.

The major findings of this study included that the instrument had a high reliability and content validity level to be used in a college population. This research is a major step toward establishing standards on health risk appraisals. Without standards, the credibility of HRAs, on a national level, will not be as substantial as it should be.

Ohio State University conducted a study to determine if health risk appraisals with personalized conferences affected the "health age" of selected undergraduates. The non-equivalent control group design involved two classes majoring in health. Two of the four groups were randomly selected.

A computerized health risks appraisal was used with questionnaires to acquire information on past and present medical history and present behaviors. The two experimental groups received a personalized lecture and

were informed of their health risk compared to the risk of the average person of the same age, gender, and race. The control group followed a college text and was not provided with an explanation about the results of their HRA. It was hypothesized that the experimental groups would increase their health age significantly over the control group. ANOVA was used to measure the effect of the HRA with the hypothesis being supported (Chenoweth, 1980).

SUMMARY

In this chapter the studies reviewed suggest that health risk appraisals can be useful tools in increasing awareness of health risk involving college students. Awareness and education are major factors in improving health on both an individual and national level. The health behavior of all individuals is the final link that can make a difference in our attitudes toward health.

The combination of improving awareness and education through HRAs and the knowledge that healthy lifestyles can affect health and health behaviors will definitely help to advance the opportunities for health promotion. The benefits college students can experience through awareness and the motivation that leads to positive health habits and

decreasing trends in chronic disease can be experienced nationwide.

CHAPTER III

METHODS AND PROCEDURES

INTRODUCTION

This chapter outlines the procedures used to complete the stated purpose of this research project. The study's population and design is discussed along with the administration of the instrument and analysis of the data.

SELECTING THE RESEARCH POPULATION

The population was selected by determining the availability of Seventh-day Adventist Colleges located in the southern United States, then locating state universities in similar geographic locations. The colleges selected for this study were located in the states of Tennessee, Florida and Texas. Upon examining with contact persons at each college, it was agreed upon to identify a study group by selection of a freshman level health class in each institution.

The goal of this study was to acquire health risk profiles from three Seventh-day Adventist College freshman students and three State University freshman students in the fall semester of 1999, and compare the results of those profiles. A target number of thirty completed health risk

questionnaires from each school was acceptable for statistical analysis. The total number of completed questionnaires would be 180. This number allows establishment of existence or nonexistence of a relationship.

THE SAMPLE METHODOLOGY

The study group consisted of six groups of college freshman students. Three groups were from Seventh-day Adventist Colleges and three groups were from State Universities. These colleges were located in the southern region of the United States.

Permission to conduct this research in the Seventh-day Adventist Colleges and State Universities was obtained by contacting the Colleges' health department heads. Telephone conferences were held to confirm requirements and set time frames for the execution of the HRAs. A letter of instruction along with the instrument was sent to each department head to resolve any concerns or questions about procedures. A specific instructor from each college was responsible for the administration of the instrument.

The researcher arranged to conduct separate instructional briefings with each of the specified instructors at each college via telephone conference. The instructors were previously requested to review the materials for any procedures that remained unclear.

All students were given an informed consent form to complete and return for recording purposes. Students were also given a research protocol sheet, which provide written instructions for completing the questionnaire.

Application for Review of Research Involving Human Subject (IRB), Form B was approved October 1999. Copies of the letter of approval, Form B, informed consent, instructor's letter and the research protocol are included in Appendix A, page 70.

INSTRUMENTATION

The instrument selected for this research project was the Eris personal risk analysis, a personalized, confidential report, which provides an overall wellness score, a risk age and an analysis of the most likely causes for premature death. This information would increase awareness among college students about lifestyle choices,

and how those choices directly affect their health. The instrument was developed by the Carter Center of Emory University in association with the Centers for Disease Control in Atlanta, Georgia. The scientific and technical basis for calculations of each precursor was developed by a panel of experts for each respective cause of premature death. For example, the cardiac heart disease calculation algorithm was developed by Brelow and Fielding (Brelow, Fielding, et al., 1985). The personal risk analysis incorporates broad base survey questions designed to produce a comprehensive health profile for individuals and groups. The instrument includes forty-six valid and reliable questions related to the following data elements: (Schoenbach, 1987), (Prochasks, 1983).

1. Basic Demographic Data
2. Family Medical History
3. Self Reported Health Status
4. Nutritional Patterns
5. Physical Activity Levels
6. Safety Belt Use
7. Exposure to Violent Acts During The Past Year
8. Tobacco Use
9. Alcohol Use

10.Preventive Services

11.Biomedical and Clinical Measures

12.Disease Management

Eris risk calculations are based on the 7 year risk factor update by the Center of Disease Control and 20 participating agencies, using 31 distinct data items from the questionnaire to calculate 10 year mortality risks for each individual and 42 causes of death. The following modifiable, quantifiable risk factors are used in specific calculation for the 42 causes of death tracked by the Personal risk analysis & Target levels:

- Tobacco Use/0 usage
- Alcohol Use/Drinks< 7 per week
- Mammograms/Annual if 50 or over
- Pap Smear/Annual
- Blood Pressure/Diastolic/Set DBP-88/Systolic/Set SBP-138
- Total/HDL Cholesterol/180
- Weight/Based on 1983 Metropolitan Weight tables
- Seat Belt/Speeding/10 mph over speed limit
- Exercise/3+ times per week

Several factors contributed to the selection of this instrument:

1. The questionnaire consisted of 47 health questions and divided into 12 specific health categories.
2. Eris has been chosen by the Center for Disease Control to manage the development of "Healthier People", the number one public domain health risk appraisal in the United States.
3. The instrument has been validated by the authors.
4. The Wellness Now Score used in the wellness thermometer is the ratio between YourRisk & TargetRisk:

   Wellness Now = TR/YR * 100.

The Eris Personal Risk Analysis questionnaire is provided in Appendix B, page 82.

PILOT TEST

A freshman class at the University of Tennessee was selected to conduct a pilot study. The instructor administered the Eris personal risk analysis to thirty students. The procedures were analyzed to determine any possible challenges involved in administering the actual questionnaire. This test procedure was recorded along with comments from subjects allowing for opportunities of improving the procedures to be recognized.

COLLECTION OF DATA

The contact person at each college involved in the research project received a letter of instruction two weeks prior to date of administration. Dates of completion were included, along with specific instruction of clinical information needed by the date of administration. This letter instructed the contact person to inform the students of the upcoming event and the requirements needed to make the study valid.

The health instructor of each freshman level class chosen for the study personally administered the instrument. A letter of instruction was sent to the instructor before the administration of the questionnaire to insure proper procedures were followed.

After two weeks from completion date any college that had not returned completed questionnaires was contacted by telephone and e-mail. Department heads were notified after a period of four weeks of no response. A second completion date was agreed upon with department head and administrating instructor. Close follow-up ensured timely and accurate data was received to complete data collection.

DATA ANALYSIS

The data were organized to address the research questions using the following procedures:

- Completed personal risk analyses were scanned through an Optical Mark Reader (OMR).
- The OMR converted the marked data and transmitted this information to the computer, which compiled it into the Personal risk analyses reports. The Personal risk analysis report can be found in Appendix B, page 86.
- The data were tabulated individually and by groups.
- Proper religious affiliation to appropriate institution was determined by inspecting ID number on questionnaire.
- The Wellness Now Scores, the average rate of overweight/obesity, the average rate of smoking, the average rate of alcohol consumption, the average MABP and the average satisfaction of life was compared through statistical analysis.
- T-tests were used to analysis the data required to address all research questions.
- The Chi Square was calculated to determine if there was a relationship between schools and obesity rates.

- The Chi Square was calculated to determine if there was a relationship between schools and smoking habits.
- An alpha level of .05 was selected as the criterion of significance for all statistical data.

SUMMARY

The Eris personal risk analysis was administered to three Seventh-day Adventist Colleges and three State Universities. The data were returned in a timely manner with the appropriate information needed to complete the analyses. Suitable procedures were performed to reveal any significant differences in the data.

CHAPTER IV

ANALYSIS AND INTERPRETATION OF DATA

INTRODUCTION

The previous chapters of this dissertation included an introduction into the study area, a review of literature related in content and methodology and the procedures used in conducting the research project. This chapter presents the analysis and interpretation of health profile results collected from 164 students of six colleges. The findings are presented under the following categories: Selected demographic characteristics of the study groups, a comparison of the selected personal health risk analysis results of the Seventh-day Adventist students and the State University students, and a discussion and analysis of the research questions.

DEMOGRAPHIC CHARACTERISTICS OF THE STUDY GROUPS

The colleges chosen for this study were determined by the availability of Seventh-day Adventist Colleges. After locating three Seventh-day Adventist Colleges, three State Universities were located in similar locations, and were designated as appropriate for the study. The students who participated in this study consisted of 164 freshman-level

college students enrolled in an introductory health class. Out of 131 health risk appraisals mailed to the three Seventh-day Adventist Colleges, 92 were returned, with 70 of those appropriate for the study. Out of 94 health risk appraisals mailed to the State Universities, 94 were returned and determined appropriate for the study. Total health risk appraisals mailed out were 225 with 164 of those being appropriate for the study. The percent of return was 73%.

Gender

Of the 164 total participants of this research project, 68 were male (41.5%) and 96 were female (58.5%). (Fig.1, page 90)*. The Seventh-day Adventist student group consisted of 25 male (36%) and 45 female (64%). (Fig.2, page 91). The State University student group consisted of 43 male (46%) and 51 female (54%). (Fig.3, page 92). The breakdown for gender can be found in the group summary report in Appendix D, page 94.

Age

The mean age of the total participants for this study was 20.8. The mean age for the Seventh-day Adventist

student group was 20.2. The mean age for the State University student group was 21.1. (Ages for all groups can be found in Fig.4, page 93). The breakdown for age can be found in the group summary report in Appendix D, page 94.

* All figures are in Appendix C.

SELECTED PERSONAL HEALTH RISK ANALYSIS RESULTS

The personal health risk analysis results included are: Wellness Now Scores, rate of overweight/obesity, mean aortic blood pressure, mean smoking score, mean alcohol consumption and the life satisfaction score. A summary of each of these personal health risk analysis results can be found in the group summary report in Appendix D, page 94.

COMPARISON AND ANALYSIS OF PERSONAL HEALTH RISK PROFILE RESULTS: SEVENTH-DAY ADVENTIST COLLEGE STUDENTS AND STATE UNIVERSITY STUDENTS

Wellness Now Scores

The mean Seventh-day Adventist Wellness Now Score was 94.1 ± 12.02. The mean State University Wellness Now Score was 74.3 ± 23.91. The t-test revealed t= 6.963. df=144.4, p<.001.

Rate of Overweight/Obesity

The Seventh-day Adventist's mean rate of overweight/obesity was 1 percent, ± 9.85, while the State University's mean rate of overweight/obesity was 5.2 percent, ± 10.38. The t-test revealed t=-2.376, df=135 and p=.019. The Chi Square=5.124, df=2 and p=.077. (See Table 1.)

Table 1: Chi Square for Overweight/Obesity

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	5.124[a]	2	.077
Likelihood Ratio	5.357	2	.069
Linear-by-Linear Association	4.607	1	.032
N of Valid Cases	137		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 5.31.

Mean Aortic Blood Pressure (MABP)

The mean aortic blood pressure for the Seventh-day Adventist students was 81.55 ± 12.76. The mean aortic blood pressure for the State University students was 88.7 ± 8.8. The t-test revealed t=-2.374, df=64, and p=.021. The mean difference between the Seventh-day Adventist and the State University is -7.2.

Smoking Score

The Chi Square revealed that there was a significant difference in the smoking scores of the Seventh-day Adventist and the State University students. Chi Square=14.886, df=2 and p=.001. (See Table 2.) When comparing the percentage of Seventh-day Adventist Students who had never smoked with State University students, the difference was 24.4 percent. When comparing the percentage of Seventh-day Adventist students who still smoked with State University students, the difference was 15.2 percent. (See Table 3.)

Table 2: Chi Square for Smoking Cigarettes

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	14.886[a]	2	.001
Likelihood Ratio	16.618	2	.000
Linear-by-Linear Association	14.559	1	.000
N of Valid Cases	170		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 8.38.

Table 3: Smoking Cigarettes, Cross-tabulation

			Smoke cigarettes?			
			Never smoked	Used to smoke	Still smoke now	Total
Type of College	Seventh Day Adventist College	Count	68	5	2	75
		% within Type of College	90.7%	6.7%	2.7%	100.0%
	State University	Count	63	15	17	95
		% within Type of College	66.3%	15.8%	17.9%	100.0%
Total		Count	131	20	19	170
		% within Type of College	77.1%	11.8%	11.2%	100.0%

Alcohol Consumption

The mean number of alcoholic beverages per week for the Seventh-day Adventist students was .2603 ± .88. The mean number of alcoholic beverages for the State University students was 7.97 ±9.69. (See Table 4.) The t-test revealed t=-7.673, df=94.983 and p<.001.

Table 4: Number of Alcoholic Beverages Per Week

Type of College		N	Minimum	Maximum	Mean	Std. Deviation
Seventh Day Adventist College	Number of alcolholic beverages per week	73	.00	5.00	.2603	.8823
	Valid N (listwise)	73				
State University	Number of alcolholic beverages per week	94	.00	50.00	7.9681	9.6881
	Valid N (listwise)	94				

Life Satisfaction

The mean satisfaction of life score for the Seventh-day Adventist students was 1.32, ± .53, while the mean satisfaction of life score for the State University students was 1.26 ± .52. The t-test revealed t=.712, df=140 and p=.477.

CHAPTER V

SUMMARY, FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

SUMMARY

Purpose of the Study

The purpose of this study was to compare the personal risk analysis results of three groups of Seventh-day Adventist College students with three groups of State University students located in the southern region of the United States. The data was gathered for this research through the application of the personal risk analysis questionnaire, developed by ERIS.

Importance of the Study

This study has the potential to support the ideology that healthy lifestyles are directly related to the prevention of disease and premature death. As their religious beliefs warrant, the Seventh-day Adventist students presumably live a healthier lifestyle than the State University students do. Health profile results reveal a healthier profile for the Seventh-day Adventist students when compared to the State University students, thus, a

direct link can be assume to exist between lifestyle and health profile results.

Procedures Followed

The total of students that completed the personal risk analysis was 164. This number consisted of 70 Seventh-day Adventist and 94 State University students. Factors such as belonging to another religion, for the Seventh-day Adventist's profiles, and falling outside the acceptable age range, for both Seventh-day Adventist and State University students eliminated 43 potential profiles from being used in the study. Students of three Seventh-day Adventist colleges and three State Universities completed the personal risk analysis in their introductory health classes. There was one Seventh-day Adventist college and one State University in each of the following states: Florida, Tennessee and Texas. All personal risk analysis were mailed out October, 1999 and all completed surveys were received back from the institutions by November 1999. The personal risk analysis results were mailed back to students within one week of processing. Risk calculations in the personal risk analysis incorporate the algorithms developed in the CDC Risk Factor Update Project and used by Eris.

FINDINGS

This research has produced findings, which are presented in the following headings: Wellness Now Score, Overweight/Obesity, Mean Aortic Blood Pressure, Smoking, Alcohol Consumption and Life Satisfaction.

Wellness Now Scores

The Seventh-day Adventist Wellness Now Score was significantly higher, $p<.001$, than the State University students.

Rate of Overweight/Obesity

The Chi Square reveals that there is no significant difference in the Seventh-day Adventist's rate of overweight/obesity.

Mean Aortic Blood Pressure (MABP)

The difference of the mean aortic blood pressure for the Seventh-day Adventist students was significantly lower than the State University students, but this difference was small enough to be considered not clinically significant.

Smoking Score

The Chi Square revealed that there was a significant difference in the proportion of smoking scores of the Seventh-day Adventist and the State University students, specifically in the categories of never smoked and still smoke now.

Alcohol Consumption

There was a significant difference in the mean number of alcoholic beverages, per week, for the Seventh-day Adventist students compared to the State University students. This was especially evident in the comparison of maximum number of alcoholic beverages consumed by Seventh-day Adventist (5) and State University students (50).

Life Satisfaction

The difference of the mean satisfaction of life score for the Seventh-day Adventist students and the State University students was not statistically significant.

FINDINGS RELATED TO THE RESEARCH QUESTIONS

RESEARCH QUESTION ONE

What were the differences between the Wellness Now scores of Seventh-day Adventist College and State University students?

The Wellness Now Scores are a reflection of lifestyle habits and indicates how these habits will affect your next ten-year life potential. The Seventh-day Adventist score of 94.1 ± 12.02 is significantly higher than the state university score of 74.3 ± 23.92. The t-test revealed $t= 6.963$. $df=144.4$, $p<.001$. These results support the assumption that healthy lifestyle habits produce better health and health potential.

RESEARCH QUESTION TWO

What were the differences between the average rate of overweight/obesity of the Seventh-day Adventist College and State University students?

The Chi Square indicated there was no significant difference with $p=.077$.

RESEARCH QUESTION THREE

What were the differences between the average mean aortic blood pressure of the Seventh-day Adventist College and the State University students?

The mean aortic blood pressure for the Seventh-day Adventist students was 81.55 $\pm$ 12.76. The mean aortic blood pressure for the State University students was 88.7 $\pm$ 8.8. While the t-test shows a significant difference, with t=-2.374, df=64, and p=.021, the mean difference between the Seventh-day Adventist and the State University is small at -7.2 and therefore is not clinically significant.

RESEARCH QUESTION FOUR

What were the differences between the average smoking score of the Seventh-day Adventist College and the State University students?

The Chi Square revealed that there was a significant difference in the smoking scores of the Seventh-day Adventist and the State University students. Chi Square=14.886, df=2 and p=.001. When comparing the percentage of Seventh-day Adventist Students who had never smoked with State University students, the difference was 24.4 percent. When comparing the percentage of Seventh-day

Adventist students who still smoked with State University students, the difference was 15.2 percent.

RESEARCH QUESTION FIVE

What were the differences between the average alcohol consumption score of the Seventh-day Adventist College and the State University students?

The mean number of alcoholic beverages per week for the Seventh-day Adventist students was .2603 $\pm$ .88. The mean number of alcoholic beverages for the State University students was 7.97 $\pm$ 9.69. The t-test reveals a significant difference with $t=-7.673$, $df=94.983$ and $p<.001$.

RESEARCH QUESTION SIX

What were the differences between average satisfaction of life score, as measured by the Personal Risk Analysis, of the Seventh-day Adventist College and State University students?

The mean satisfaction of life score for the Seventh-day Adventist students was 1.32 $\pm$ .53, while the mean satisfaction of life score for the State University students was 1.26 $\pm$ .52. The t-test revealed no significant difference with $t=.712$, $df=140$ and $p=.477$.

CONCLUSIONS

The following conclusions are based on the findings of this research study:

1. The Wellness Now Scores of the Seventh-day Adventist students were significantly better than the Wellness Now Scores of the State University students. The final conclusion is that healthy lifestyles have a profound affect on projected years of living.
2. When comparing the personal risk analysis results of the Seventh-day Adventist students and the State University students, there was no significant difference in rate of overweight/obesity. The conclusion that lifestyle affects rate of overweight/obesity is not substantiated from this data.
3. Due to the small margin of difference of MABP between the Seventh-day Adventist students and the State University students, blood pressure is not an indicator of poor lifestyle habits between these two groups.

4. When comparing the personal risk analysis results of the Seventh-day Adventist students and the State University students, the difference of the proportion of students who had never smoked and who still smoked was statistically significant. The conclusion that smoking can have a significantly negative affect on an individual's health is supported by these results.
5. When comparing the personal risk analysis results of the Seventh-day Adventist students and the State University students, the difference in the low alcohol consumption rate of the Seventh-day Adventist and the high alcohol consumption rate of the State University students was statistically significant. These results support the conclusion that a high alcohol consumption rate can have a significantly negative affect an individual's projection of healthy years to live.
6. In life satisfaction, it was concluded that the State University students do not view health as a requirement to be satisfied with their lives.

RECOMMENDATIONS

The following recommendations result from the findings and conclusions based on the data produced by this research:

1. Healthy lifestyles should be the foundation of all health promotion goals and objectives and the interwoven theme of all health related disciplines (the seven dimensions of wellness).
2. Health promotion and education should incorporate health behaviors as the basis for program design and implementation. These programs must influence positive health behavior choices on an individual level that can sustain long-term benefits.
3. Constant evaluation of the long-term and short-term consequences of poor, as well as positive, health behaviors choices should be a driving force for all levels of health promotion policy makers (local, state, and national).

RECOMMENDATIONS FOR FURTHER RESEARCH

1. A study, which included a substantially larger sample, would allow for results that are more comprehensive.
2. Research involving a more diverse age group would permit actual consequences versus projected consequences to be examined, when comparing health behaviors of study groups.
3. Further research on the effects of religious convictions and social support need to be conducted.
4. Studies should also be conducted on the effects of life satisfaction as compared to quality, as perceived by the individual, versus quantity.
5. A comparative study, which focused on different cultures should be conducted to investigate how the many diverse socialization processes can influence lifestyle habits and their effects on health.

CHAPTER VI

EPILOGUE

The purpose of this study was to compare the personal health profile results of Seventh-day Adventist college students with those of State University students, ages 18-29 in the southern region of the United States. This health profile was obtained through the use of the Eris Personal Health Analysis.

The knowledge obtained through this study would contribute to the following objectives:

1. Help to substantiate to policy-makers in government that healthcare decisions must promote prevention.
2. Encourage students to continue healthy habits or improve unhealthy habits.
3. Incorporate health risk profiles in all aspects of health care to promote awareness.

OBSERVATIONS OF THE RESEARCH

The comparison of Seventh-day Adventist students' health profile results and State University students' health profile results proved beneficial for the support of prevention-based health care. A significant difference in Wellness Now Scores upholds the ideology that you are

never too young to start practicing preventive health care.

Social support may influence health both directly and indirectly by buffering the effects of severe life stressors. Integration into a social network may mean that individuals experience greater attachment and higher self-esteem, and have a feeling of greater personal control (Rutter, 1993).

Influences on an individual's choice of positive or negative health behaviors are issues that continually challenge psychologists, sociologists and health educators alike. There are multiple factors in an individual's life that could establish a behavior that will continue for a lifetime. Factors that account for individual differences in the inclination to undertake health behaviors include: demographic factors, social factors, emotional factors, perceived symptoms factors relating to access medical care, personality factors and cognitive factors. Along with these factors, conditions that encourage positive health behaviors change would need to include education restructuring and behavior modification (Storer, 1997).

It is increasingly recognized that individuals can make major contributions to their own health and well

being through the adoption of particular health-enhancing behaviors (e.g. exercise) and the avoidance of other health compromising behaviors (e.g. smoking) (Conner, 1996). An idea that has long been supported by clinicians and various religious and community groups is that a relationship exists between good health and such personal habits as regulation of meals and sleep, moderation in food and alcohol consumption and moderate exercise (Feuerstein, 1986).

Several considerations must be taken into account when analyzing this set of data. The results of the Seventh-day Adventist students' Life Satisfaction score as compared to the State University students' score was lower, although all physical aspects of the results gave favor to the Seventh-day Adventist students. This could be related to the religious influence affecting Seventh-day Adventists' expectations of life and that, possible, they are prone to a more disciplined outlook on life. This is simply an observation without data to substantiate these remarks.

Social contact and close ties have been shown to have a relationship with feelings of well being and satisfaction with life. Social contact may be maintained with family members, such as parents, siblings, children

or spouse, or the contact may be with friends that have similar interests. Regardless of the source of social contact, it was found that contact with other people reduced depression and stress. (Gillis 1994). There may be more opportunity for social contact at State Universities than at Seventh-day Adventist Colleges accounting for the difference in Life Satisfaction Scores.

Another consideration one should realize is the percentage of female versus male in the two groups studied. The percentage of female versus male in the Seventh-day Adventist group was 64.3% female and 35.8% male. The percentage of female versus male in the State University group was 54.3% female and 45.7% male. There were 20% more females as compared to males in the Seventh -day Adventist group than the State University group. Research has shown that by way of generalization, females tend to have a healthier lifestyle than males (Patterson, 1992). With this taken into account, it is unknown how much of a factor gender would influence the results of the health risk profiles.

The health risk status of each group is data that does not address the research questions of this study, yet reveals significant differences between the groups and

should be mentioned. When observing health and safety practices between these two groups, the Seventh-day Adventist students had 81% low risk, 1% moderate risk and 17% high risk, while the State University students had 24% low risk, 9% moderate risk and 66% high risk. High risk individuals are at significant risk for early death from disease or accidents.

The significant risk factors that influenced the health risk status scores of the Seventh-day Adventist students were seat belts 9%, alcohol 33% and speeding 55%. The significant risk factors that influenced the health risk status scores of the State University students were speeding 10%, seat belts 11% and alcohol 78%.

In preventable causes of death, both groups were overwhelmingly predicted to die of accidents. Seventh-day Adventists students 97% and State University students 98%.

The group profile risk factors are compared to the general population and to the target goals of Healthy People 2000. These results can be seen in Appendix E, page 116.

STRENGTHS AND WEAKNESS OF THE STUDY

One of the strengths of this study is the opportunity that the instructors had to promote awareness in the groups studied. The young age of this groups was an indicator that many of these students had never taken a health risk profile. The exercise of filling out the questionnaire helps to increase awareness and hopefully increase the possibility that unhealthy habits will be replaced with new, healthier habits.

Many students that had been given the HRA to fill out were very interested in the results they were given as part of the study. They agreed that the act of filling out the health risk profile helped them to realize that some of their habits could be improved and a conscious effort would be made to work on them.

The research project would have been more credible if there had been a larger sample of participants. Due to the vast geographical layout of the study, the samples were smaller than desired.

SEVENTH-DAY ADVENTIST AND HEALTH

Seventh-day Adventists as a part of their religious experience accepted the health reform movement of the 19th Century. Health reform was seen as a means to bring man's behavior in harmony with the divine laws of the human organism in order to develop a healthy constitution (Damsteegt, 1977). By the early 1860s, Adventist publications discouraged the use of tobacco, tea, and coffee and many church members were practicing vegetarianism (Land, 1986).

The Seventh-day Adventists' health emphasis is evident in their philosophy and belief that man was created by a higher power who formed him and placed him under laws that would maintain him physically, mentally and spiritually. These laws include the proper use of water, sunshine, fresh air, diet, exercise, adequate rest and sleep, trust in Divine Power and abstinence of harmful substance to the body. Seventh-day Adventists call these beliefs the "Eight Laws of Health" (Greek, 1987).

In research conducted on religious beliefs and health status, the Seventh-day Adventists was found to have the best health practices (Kondo, 1980). These results were expected because healthful behaviors are an integral part

of their religion. Suggestions were made that church attendance may influence the occurrence of chronic illness. A particular socio-cultural environment may exist among those who devote substantial portions of their lives to their religion. This environment produces the behavioral standards from which positive health practices are established.

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APPENDICES

APPENDIX A

LETTER OF APPROVAL
FORM B
INFORMED CONSENT
INSTRUCTOR'S LETTER
RESEARCH PROTOCOL

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10/19/99

IRB # : 5782 B

Title : A Comparative Study of Health Risk Profile Results Between Seventh Day-Adventist College Students and Public College Students

Watkins, Cecilia	Pursley, Dr. Robert
Health & Safety Sciences	Health & Safety Sciences
1165 Keowee Ave., Apt. E-5	1914 Andy Holt Ave.
Knoxville, TN 37919	Campus

Your project listed above was reviewed. It qualified for expedited review and has been approved.

This approval is for a period ending one year from the date of this letter. Please make timely submission of renewal or prompt notification of project termination (see item #3 below).

Responsibilities of the investigator during the conduct of this project include the following:

1. To obtain prior approval from the Committee before instituting any changes in the project.
2. To retain signed consent forms from subjects for at least three years following completion of the project.
3. To submit a Form D to report changes in the project or to report termination at 12-month or less intervals.

The Committee wishes you every success in your research endeavor. This office will send you a renewal notice (Form R) on the anniversary of your approval date.

Sincerely,

Brenda Lawson

Brenda Lawson
Compliances

cc: Charles Hamilton

FORM B

IRB#_____

Date Received in Office of Research _____

THE UNIVERSITY OF TENNESSEE, KNOXVILLE

Application for Review of Research Involving Human Subjects

I. IDENTIFICATION OF PROJECT

1. **Principal Investigator(s) and/or Co-Principal Investigator(s):**

   Cecilia Watkins, 1165 Keowee Avenue, Apartment E-5, Knoxville, TN 37919. Phone 423-595-4440.
   Dr. Robert J. Pursley, Department of Health and Safety Sciences, 1914 Andy Holt Avenue, Knoxville, TN 37996-27000. Phone 423-974-5041.

   Faculty Advisor: Dr. Robert J. Pursley

   Department/unit: Health and Safety Sciences

2. **Project Classification:** Dissertation

3. **Title of Project:** Personal Health Risk Analysis of Seventh-day Adventist College Students and State University College Students: A Comparative Study.

4. **Starting Date:** (NO RESEARCH MAY BE INITIATED UNTIL Certification IS GRANTED.) October 1999.

5. **Estimated Completion Date:** (Include all aspects of research and final write-up) April 2000.

6. **External Funding:** None

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II. PROJECT OBJECTIVES

The purpose of this study is to compare the personal health risk analysis of three groups of Seventh-day Adventist College Students with three groups of State University College Students in the southern region of the United States.

Research Questions include:

1. What were the differences between the Wellness Now scores of Seventh-day Adventist College and State University students?
2. What were the differences between the average rate of overweight/obesity of the Seventh-day Adventist College and State University students?
3. What were the differences between the average mean aortic blood pressure of the Seventh-day Adventist College and the State University students?
4. What were the differences between the average smoking score of the Seventh-day Adventist College and the State University students?
5. What were the differences between the average alcohol consumption score of the Seventh-day Adventist College and the State University students?
6. What were the differences between average satisfaction of life score, as measured by the Personal Risk Analysis, of the Seventh-day Adventist College and State University students?

III. DESCRIPTION AND SOURCE OF RESEARCH PARTICIPANTS:

The sample population studied is six groups of freshman students. Three groups are from Seventh-day Adventist colleges and three groups are from state universities. These colleges are located in the southern region of the United States and include a total of approximately 200 students.

The population was selected by determining the availability of Seventh-day Adventist colleges located in the southern United States, then locating state universities in similar geographic locations. The colleges selected for this study is located in the states of Tennessee, Florida and Texas.
Upon examining with contact persons at each college the options of methods used to obtain a sample population, it was agreed upon to identify a sample population by random selection of a freshman health class in each institution. This method of cluster sampling is appropriate due to the similarities of the groups and the large geographic area.

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IV. METHODS OR PROCEDURES:

A. Tasks

All students will be given an informed consent form. (See attached form)
A freshman class at the University of Tennessee will be randomly selected to conduct a pilot study. The instructor will administer the *ERIS* personal risk analysis to a small sample of students. The procedures will be analyzed to determine any possible challenges involved in administering the actual questionnaire. The test procedures will then be recorded along with comments from subject allowing for suggestions of improving the procedures.

The department head at each college involved in the research project will receive a copy of the research protocol.

The instructor of each freshman class chosen for the study will personally administer the instrument. Instructions will be sent to the professor along with the instrument prior to the administration of the questionnaire to insure proper procedures are followed. All of the instruments will be administered and data collected between October and November 1999 by participating colleges and universities.

Coded packets consisting of a scan sheet and survey will be distributed to those who volunteer and sign an informed consent sheet. Subjects will also be assured confidentiality and anonymity will be held to the highest level.

V. SPECIFIC RISKS AND PROTECTION MEASURES

This project holds no risk as defined by PER 45 CFR 46.101(b), to subjects participating in this study. The participant's role involves responding to a standardized health risk survey. Information gathered from this study will be used to substantiate the connection between healthy lifestyles and positive health results.

Anonymity applies for this project, as the principal investigator will not have access to participant names, only unique identifiers known only to the responder. Materials will be stored in a locked file cabinet in HPER Building, Room 373 at the University of Tennessee, Knoxville, TN campus. Data will be converted to electronic data and hardcopy will be destroyed within 30-60 days. Consent forms will be stored for a period of 3 years following completion of the research in the locked file cabinet in HPER Building, Room 373. Confidentiality also applies and each participant will be assured of this both in the informed consent form and the briefing session with the instructor.

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VI. BENEFITS

Each participant will receive an individualized computer printout with advisory messages based on their answers.

VII. METHODS FOR OBTAINING "INFORMED CONSENT" FROM PARTICIPANTS

Each participating instructor will distribute a research protocol form and an informed consent form to students attending class on the day selected for data collection. The instructor will read the text of the document titled "Research Protocol" to the class. (see attached research protocol form). Students who consent to participate in the project will sign the consent form, complete the health risk appraisal, add their selected anonymous ID number code and return to the instructor. The instructor will place all materials in a preaddressed stamped envelope and mail to the PI. Signed informed consent documents will be kept for the duration of the project and for at least three years thereafter in a locked file cabinet in HPER Building, Room 373.

VIII. QUALIFICATIONS OF THE INVESTIGATOR(S) TO CONDUCT RESEARCH

Dr. Pursley has over 20 years of experience in conducting research using Health Risk Appraisals. Ms. Watkins has over 10 years of experience working with the public in the area of health and fitness assessment.

IX. FACILITIES AND EQUIPMENT TO BE USED IN THE RESEARCH

The health risk appraisal is a paper and pencil instrument that is subsequently optically scanned and analyzed by computer. The *ERIS* instrument will be read and analyzed using software provided by the corporation that owns the copyright on the instrument. No names are included in the analysis; only the anonymous ID number code selected by each participant and affixed to the survey is entered into the computer database that results from the analysis. Health risk appraisal reports will be printed by the software program and will be returned for distribution to participants. They will be retrieved by each participant recognizing the anonymous ID number code, which was affixed to their original survey form.

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RESPONSIBILITY OF THE PRINCIPAL/CO-PRINCIPAL INVESTIGATOR (S)

Ms. Watkins will assume responsibility for obtaining permission from each institution willing to participate in the project. She will also send all materials to course instructors and will receive completed health risk appraisal forms. Ms. Watkins will also scan and analyze completed forms, return appraisal reports to instructors for distribution to volunteers, and will analyze and store data. Dr. Pursley will supervise the project and will assist with interpreting statistical results.

By compliance with the policies established by the Institutional Review Board of The University of Tennessee, Knoxville, the principal investigator(s) subscribe to the principles stated in "The Belmont Report" and standards of professional ethics in all research, development, and related activities involving human subjects under the auspices of The University of Tennessee, Knoxville. The principal investigators further agree that:

1. Approval will be obtained from the Institutional Review Board prior to instituting any change in this research project;
2. Development of any unexpected risks will be immediately reported to the Compliance's Section.
3. An annual review and progress report (Form R) will be completed and submitted when requested by the Institutional Review Board.
4. Signed informed consent documents will be kept for the duration of the project and for at least three years thereafter at a location approved by the Institutional Review Board.

UNIVERSITY OF TENNESSEE

A COMPARATIVE STUDY OF HEALTH RISK PROFILE RESULTS BETWEEN SEVENTH-DAY ADVENTIST COLLLEGE STUDENTS AND PUBLIC COLLEGE STUDENTS.

INFORMED CONSENT

As a doctoral student in Health Education at the University of Tennessee, I am conducting a study on the health profiles of Seventh Day Adventist freshman college students as compared to public freshman college students. I would appreciate your participation in this research.

The study involves a computerized health risk appraisal, which was developed by *ERIS*, specialists in healthcare information. This instrument incorporates a broad base of survey questions designed to deliver a comprehensive health profile for individuals.

This research is important in gathering specific health profile results that (could) be results of a healthier lifestyle. As a result of participating in this study, you will receive an individualized computer printout with advisory messages based on your answers. Your response will be completely confidential, identified by number only.

Participation is voluntary and you may withdraw at any time. There are no anticipated risks. Nonparticipation is without penalty.

Consent forms will be stored in a locked file at a University of Tennessee, Knoxville location for three years past the completion of the study.

If you are willing to participate in this study, please complete the form at the bottom of this page. If you have any questions or concerns, I will be glad to answer them at any time. Thank you for your cooperation.

Sincerely,

Dr. Robert J. Pursley
Committee Head
Department of Health and Safety Sciences
1914 Andy Holt Avenue
Knoxville, TN 37996-2700
423-974-5041

Cecilia Watkins, MS
Doctoral Student
Department of Health and Safety Sciences
1914 Andy Holt Avenue
Knoxville, TN 37996-2700
423-974-5041

I, _____ agree to participate in the *ERIS* personal risk analysis. I have been informed as to the nature of the study and the report form I will receive. I understand that in order to obtain my report, I will need to produce the numbered tab I will receive upon turning in the form. I have received a copy of this consent form.

APPROVED
By Brenda Lawson
Date 10-19-99

_____
Printed Name

_____ _____
Signature Date

September, 1999

Dear Instructor,

I am Cecilia Watkins; a doctoral student attending the University of Tennessee conducting research on health risk profiles results of Seventh day Adventist freshman college students as compared to public freshman college students. Information gathered from this study will be used to substantiate the connection between healthy lifestyles and positive health results.

Your cooperation is sought to have a faculty person collect data by having an introductory health class participate in the study. Students, on a volunteer basis, in the health class would complete a questionnaire that will require about 20 minutes. All information received will be treated anonymously and confidentially. I have a premier doctoral committee monitoring the project.

Your instructor can easily administer the instrument. Blood pressure, cholesterol and weight should be obtained by the students previously, or current data will suffice. A copy of the instrument and instructions are enclosed.

Your institution's participation is vital to the success of this project. Results will be returned to you to share with your participants. If you agree to be included in this project, please send a letter of confirmation to this return address.

Thank you for your consideration and participation in this research project. Should you or your faculty have any questions regarding this research study, please feel free to contact me at (423) 595-4440 or cwatkins@utk.edu.

Sincerely,

Cecilia Watkins MS

RESEARCH PROTOCOL

Your participation in this research is strictly voluntary. You may elect to return the incomplete questionnaire at any time.

All questions should be answered as truthfully and completely as possible.

All information will be kept in strictest confidence, with data linked only to a unique identifier number that only the participant will know.

The Participant ID number will consist of the following:
The first two spaces will be for your university:

01 University of Tennessee, Knoxville, TN
02 Southern Adventist University, Collegedale, TN
03 University of Florida, Gainesville, FL
04 Florida Hospital of Health Sciences, Orlando, FL
05 Southwest Texas State University, San Marcos, TX
06 Southwest Adventist University, Keene, TX

The next two spaces will be your mother's birth month:

01 January
02 February
03 March
04 April
05 May
06 June
07 July
08 August
09 September
10 October
11 November
12 December

The next four will be the last four numbers of your social security number.

The last number will be your religious affiliate.

1 Seventh-day Adventist
2 Catholic
3 Baptist
4 Methodist
5 Lutheran
6 Episcopalian
7 Jewish
8 Other Protestant
9 Other

If you have a question raise your hand. We will respond to your question at your desk.

Please use a #2 pencil and press firmly.

Note:
To be read to research subjects before completing ERIS HRA.

APPENDIX B

PERSONAL RISK ANALYSIS QUESTIONNAIRE
PERSONAL RISK ANALYSIS REPORT

Personal Risk Analysis

This questionnaire will ask you about your health and lifestyle habits. Your answers will be entered into a computer program. Your confidential personal report will give you information about your major health risks, your healthy habits, and habits you might change to reduce your risks.

This Health Risk Appraisal is NOT a substitute for a physical check-up; it can't tell you if you are sick. It can give you ideas for healthy living and for minimizing your risks of being sick or injured in the future. It is not designed for people who have heart disease, cancer, kidney disease, or have other serious problems. If you have one of these conditions and want to do a health risk appraisal, please ask your doctor or nurse to go over the report with you.

Please fill in your responses like this using a No. 2 Pencil



1. AGE - in years

Age	
	0
10	1
20	2
30	3
40	4
50	5
60	6
70	7
80	8
90	9

PARTICIPANT ID NUMBER

0	0	0	0	0	0	0	0	0
1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5	5
6	6	6	6	6	6	6	6	6
7	7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9	9

2. SEX MALE ○ FEMALE ○

3. Race:

Aleutian, Alaska native, Eskimo or American Indian
Asian White
Black Other
Pacific Islander Don't know

4. Are you of Hispanic origin such as Mexican-American, Puerto Rican or Cuban?
Yes ○ No ○

5. Have you ever been told that you have diabetes *(or sugar diabetes)*?
Yes No

6. Are you now taking medicine for high blood pressure? Yes ○ No ○

7. In general, how satisfied are you with your life? Mostly satisfied Not satisfied
Partly satisfied

8. Do you eat some food every day that is high in fiber, such as whole grain bread, cereal, fresh fruits or vegetables?
Yes ○ No ○

9. Do you eat some food every day that is high in cholesterol or fat, such as fatty meat, cheese, fried foods or eggs?
Yes No

10. In an average week, how many times do you engage in physical activity *(exercise or work which lasts at least 20 minutes without stopping and which is hard enough to make you breathe more heavily and your heart beat faster)*?
Less than 1 time per week ○
1 or 2 times per week ○
At least 3 times per week ○

Traveling

11. In the next 12 months how many thousands of miles will you probably travel by each of the following? *(NOTE: U.S. average for cars is 10,000 miles)*
    a. Car, Truck, or Van:
    b. Motorcycle:
    (For example, if your answer is 5,000 mark 00, and 5)

11a. Car/Truck Van .000

11b. Motorcycle .000

12. If you ride a motorcycle or all-terrain vehicle *(ATV)* what percent of the time do you wear a helmet?
    - Less than 25%
    - 25% to 74%
    - 74% to 100%
    - Does not apply to me

13. On a typical day, how do you USUALLY travel?
    - Walk
    - Bicycle
    - Motorcycle
    - Sub-compact or compact car
    - Mid or Full-size car
    - Truck or Van
    - Bus, subway or train
    - Mostly stay home

14. What percent of the time do you usually buckle your safety belt when driving or riding?
    - Never, 0%
    - Seldom, 1-39%
    - Sometimes, 40-79%
    - Usually, 80-99%
    - Always, 100%

15. On the average, how close to the speed limit do you usually drive?
    - Within 5 mph
    - 6 - 10 mph over
    - 11 - 15 mph over
    - More than 15 mph over

Tobacco Use

16. How many cigars do you usually smoke per day?
17. How many pipes of tobacco do you usually smoke per day?
18. How many times per day do you usually use smokeless tobacco? *(Chewing tobacco, snuff, pouches, etc.)*
    - None / 1 / 2 or more
    - None / 1 / 2 or more
    - None / 1 / 2 or more

19. **DO YOU SMOKE CIGARETTES?**
    How would you describe your cigarette smoking habits?
    - Never smoked — GO TO QUESTION 22
    - Used to smoke — GO TO QUESTION 21
    - Still smoke now — GO TO QUESTION 20

20. **IF YOU SMOKE NOW** *Answer 20*
    How many cigarettes a day do you smoke?

20. Cigarettes Now

21. **IF YOU USED TO SMOKE** *Answer 21 a & b*
    a. How many years has it been since you smoked cigarettes fairly regularly?
    b. What was the average number of cigarettes per day that you smoked in the 2 years before you quit?

    For example, if your answer is 5, mark 00 and 5.

21a. Years Quit

21b. Cigarettes Before Quit

Alcohol Use

22. How many times in the last month did you drive or ride when the driver had perhaps too much alcohol to drink?

23. How many drinks of alcoholic beverages do you have in a typical week? A drink is a 12 oz. bottle or con of beer, a 5 oz. glass of wine, a 12 oz. wine cooler, or a shot of liquor.

    For example, if your answer is 7, mark 00 and 7.
    If you don't drink, mark 0.

22. Drinking and Driving

23. Alcoholic Drinks

Women Only



24. At what age did you have your first menstrual period?

11 or under 12-13 14 or older

25. How old were you when your first child was born?

No Children ○ 20-24 ○ Over 29 ○
Under 20 ○ 25-29 ○

26. About how long has it been since your last breast x-ray *(Mammogram)*?

Less than 1 year ago 3 or more years ago
1 year ago Never
2 years ago

27. How many women in your natural family *(mother and sisters only)* have had breast cancer?

None ○ 2 or more ○
One ○ Don't know ○

28. Have you had a hysterectomy operation? *(Removal of your uterus)*

Yes No

29. When did you last have a Pap smear?

Less than 1 year ago ○ 3 or more years ago ○
1 year ago ○ Never ○
2 years ago ○

30. How often do you examine your breasts for lumps?

Monthly Rarely or never
Once every few months

31. When did you last have your breasts examined by a physician or nurse?

Less than 1 year ago ○ 3 or more years ago ○
1 year ago ○ Never ○
2 years ago ○

32. About how long has it been since you had a rectal exam?

Less than 1 year ago 3 or more years ago
1 year ago Never
2 years ago

Men Only

33. About how long has it been since you had a rectal or prostate exam?

Less than 1 year ago ○ 3 or more years ago ○
1 year ago ○ Never ○
2 years ago ○

Men & Women

34. How many times in the last year did you witness or become involved in a violent fight or attack where there was a good chance of a serious injury to someone?

4 or more times 1 time or never
2 or 3 times Not sure

35. Have you suffered a personal loss or misfortune in the past year that had a serious impact on your life? *(For example, a job loss, disability, separation, jail term, or the death of someone close to you.)*

Yes, 1 serious loss or misfortune ○
Yes, 2 or more ○
No ○

36. Considering your age, how would you describe your overall physical health?

Excellent Fair
Good Poor

37. What is the highest grade you completed in school?

Grade school or less ○ Some college ○
Some high school ○ College graduate ○
High school graduate ○ Post graduate or professional degree ○

38. What is your job or occupation? ***(Mark only one)***

○ Student	○ Unemployed	○ Manager, educator, professional
○ Retired	○ Skilled crafts	○ Technical, sales or administrative support
○ Service	○ Health professional	○ Other
○ Homemaker	○ Operator, fabricator, laborer	

39. In what industry do you work (or did you last work)? ***(Mark only one)***

Mining	Electric, gas, sanitation
Government	Wholesale or retail trade
Construction	Agriculture, forestry, fishing
Manufacturing	Transportation, communication
Other	Financial and service industries

40. Body frame size ○ Small ○ Medium ○ Large

41. HEIGHT *(without shoes)*

Feet	Inches
	0
	1
	2
	3
4	4
5	5
6	6
7	7
	8
	9
	10
	11

EXAMPLE
If your height is 5 feet - 6 inches enter as

Feet	Inches
5	6

42. WEIGHT *(without clothes)*

In Pounds		
000	00	0
100	10	1
200	20	2
300	30	3
400	40	4
500	50	5
	60	6
	70	7
	80	8
	90	9



43. What is your TOTAL cholesterol level *(based on a blood test)*?

Total Chol.		
000	00	0
100	10	1
200	20	2
300	30	3
400	40	4
500	50	5
	60	6
	70	7
	80	8
	90	9

44. What is your HDL cholesterol *(based on a blood test)*?

HDL Chol.		
000	00	0
100	10	1
200	20	2
	30	3
	40	4
	50	5
	60	6
	70	7
	80	8
	90	9

45. What is your blood pressure now?

Blood Pressure					
Systolic (high No.)			Diastolic (low No.)		
000	00	0	000	00	0
100	10	1	100	10	1
200	20	2	200	20	2
300	30	3		30	3
	40	4		40	4
	50	5		50	5
	60	6		60	6
	70	7		70	7
	80	8		80	8
	90	9		90	9

46. If you do not know the numbers, mark the box that describes your blood pressure.

High
Normal or low
Don't know

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Personal Risk Analysis

There are some factors affecting your health that you can't change - like your sex and age. Other factors are under your control. This report stresses the things **YOU CAN DO** to protect your health.



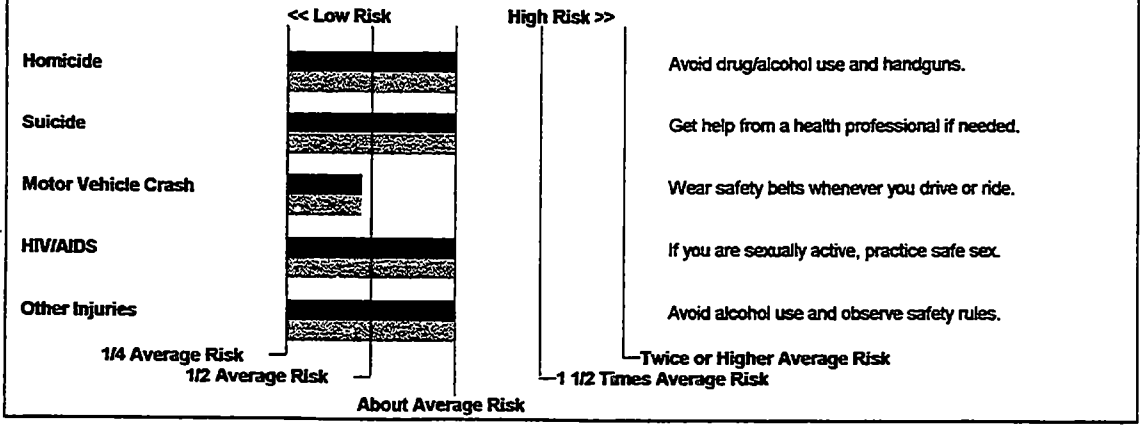
Based on your answers to the Personal Risk Analysis questionnaire, your Wellness Score is 100. You have acheived the top score for the Wellness measure!

GOOD HABITS	TO IMPROVE YOUR RISK PROFILE:	WELLNESS POINTS TO GAIN:
+ You don't smoke + Low alcohol risk + Weight (160) is in the desirable range + Good seat belt use + Safe driving speed + You don't use smokeless tobacco + Good exercise habits (3+ TIMES A WEEK)	- Reduce fat in your diet - Eat more high-fiber foods	* *

* *Starred items are important habits for which an exact risk could not be calculated. Even though we can't predict your risk gain in numbers, each of these is important, possibly even more important than those with numbers.*

This chart tells how you rank on leading health risks for a man of 22:

Top Risks for Man of 22: ■ = Your risk now. ▒ = With recommended changes.



These changes would lower your risks:

- Avoid drug/alcohol use and handguns.
- Get help from a health professional if needed.
- Wear safety belts whenever you drive or ride.
- If you are sexually active, practice safe sex.
- Avoid alcohol use and observe safety rules.

BASIC HEALTH MEASURES:

Blood pressure:	LOW OR NORMAL (estimate by participant)	The ideal range is 138/88 or under
Cholesterol:	(missing)	The ideal range is 180 or under
HDL:	(missing)	Ratio: (not available)
Diabetes:	NO	You reported that you don't have diabetes.
Weight:	160 lbs.	Height: 6' 0" ** about right ** The ideal range for MEDIUM frame is 154 - 170

ROUTINE PREVENTIVE SERVICES FOR MEN YOUR AGE

Dental exam
Blood Pressure and Cholesterol test
Prostate & Rectal exam
Measles-Rubella vaccine (if not already immune)
Tetanus-Diphtheria booster shot (every 10 years)

GENERAL RECOMMENDATIONS FOR EVERYONE

* Exercise briskly for 15 - 30 minutes at least three times a week
* Use good eating habits by choosing a variety of foods that are low in fat and cholesterol and high in fiber
* Learn to recognize and handle stress - get help if you need it

*** MORE ABOUT YOUR PERSONAL RISKS... WITH SUGGESTIONS ***

YOU'RE A NON-SMOKER:
By not smoking you have avoided THE number-one preventable cause of illness and death.

WEIGHT:
Your weight of 160 pounds does not exceed the desirable range (154 - 170 lbs) for your height of 6' 0" and MEDIUM frame size.

EXERCISE: 3+ TIMES A WEEK:
Continue to exercise regularly, 3-5 times per week, to maintain ideal body weight and optimal health.

DIETARY FATS:
You reported that you eat foods like fatty meats and eggs every day. At any age, eating a lot of food high in saturated fat is risky. It can lead to problems like hardening of the arteries (arteriosclerosis) and obesity. You can help by eating less fried foods, meat, cheese, and whole milk.

DIETARY FIBER:
You reported that you don't eat high-fiber foods on a daily basis. Eating high fiber foods reduces your risk of certain cancers. Fiber should be part of any balanced diet. Examples of high fiber foods include: whole grain cereals and breads, fruits, and some vegetables like peas and beans.

YOUR ALCOHOL USE, 3 DRINKS PER WEEK, IS MODERATE:
By keeping your alcohol consumption at a moderate or low level, you help protect your health, your family, and your career.

PERSONAL LOSS:
You reported having serious personal loss in the past year. If this or other stress is causing problems for you, find ways to talk it over with someone you trust. Don't let your problems build up until the stress affects your health.

IF YOU ARE SEXUALLY ACTIVE:
You can prevent sexually transmitted diseases, including AIDS, as well as preventing unwanted pregnancies, by safe sex practices such as the use of condoms. For more information, contact your local health care provider. For specific information on AIDS, call the national AIDS hotline at 1-800-342-AIDS (2437).

****

This Health Risk Appraisal is different from an examination by a doctor or other health care provider. It can't diagnose illness or identify medical problems. It **does** identify areas of risk that you can improve by making lifestyle changes. Build a plan of action, get help if you need it... and make changes gradually. If you have lots of changes, it's best to tackle a few at a time. Whether it's a little weight you want to lose, a cigarette habit that needs to go, or just remembering to fasten your seat belt every time you drive, you **CAN** succeed. You'll feel better and improve your odds for a long and healthier life if you do. Good Luck!

APPENDIX C

FIGURES

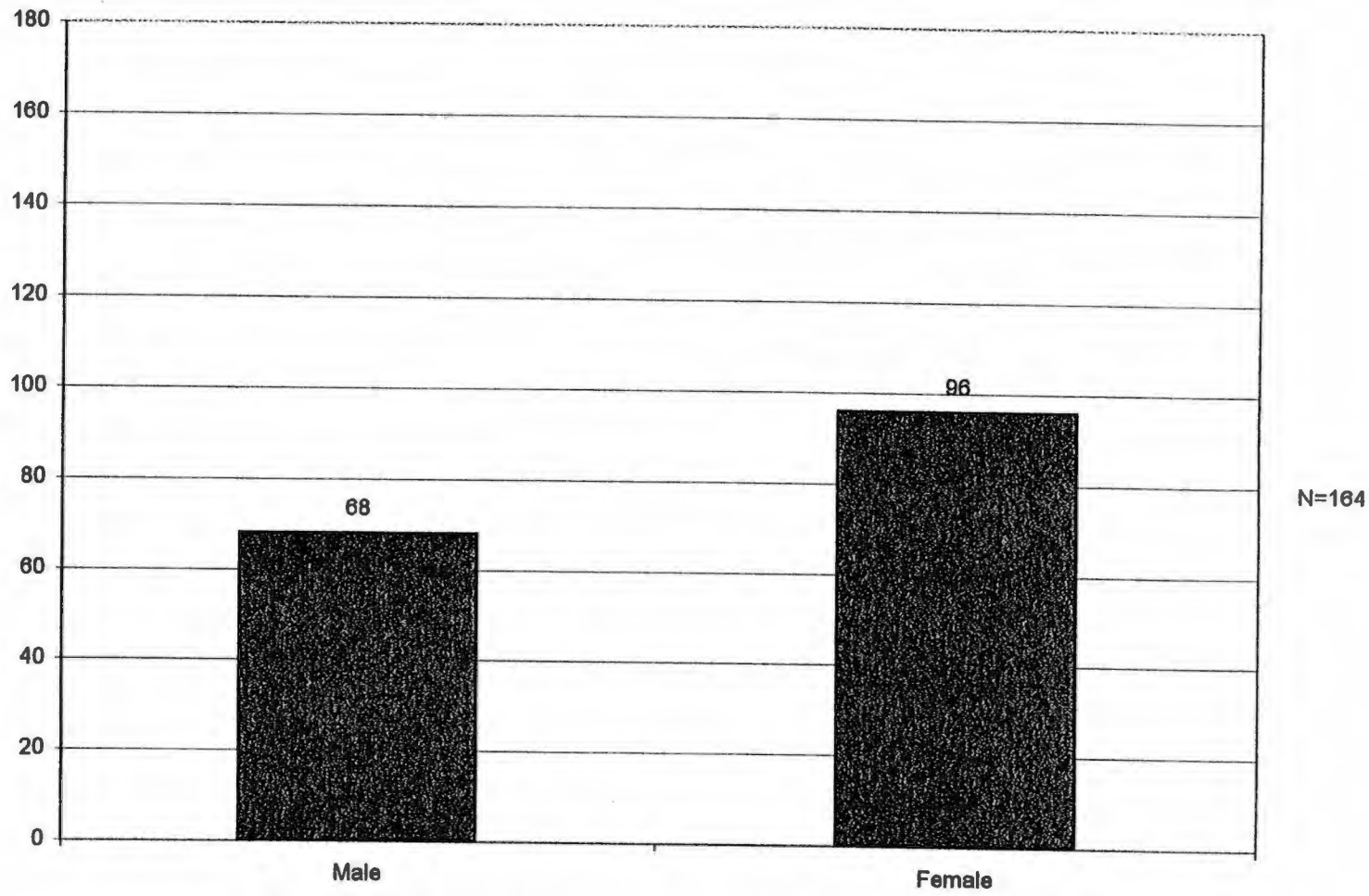


Figure 1. Total Participants of Study by Gender

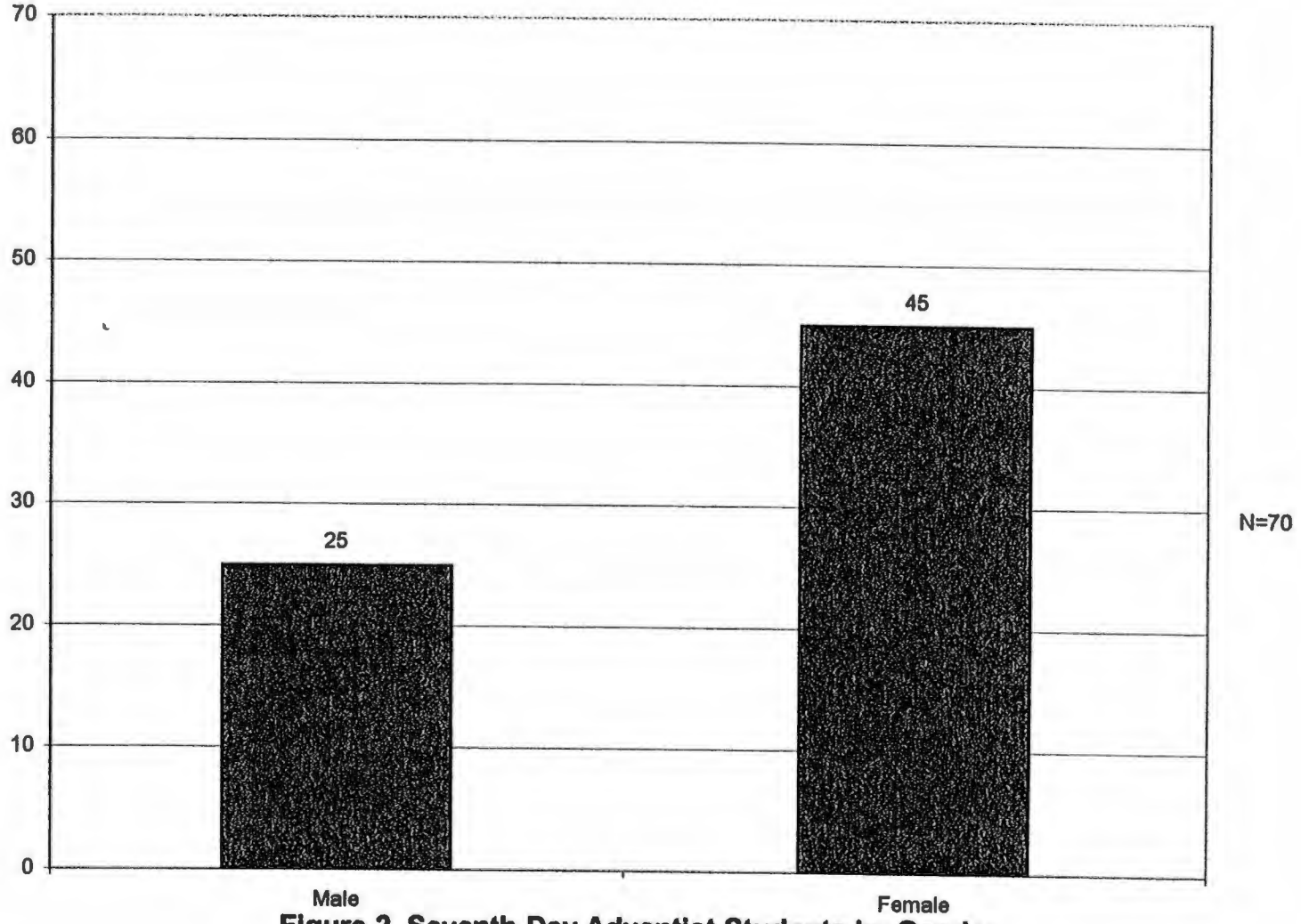


Figure 2. Seventh-Day Adventist Students by Gender

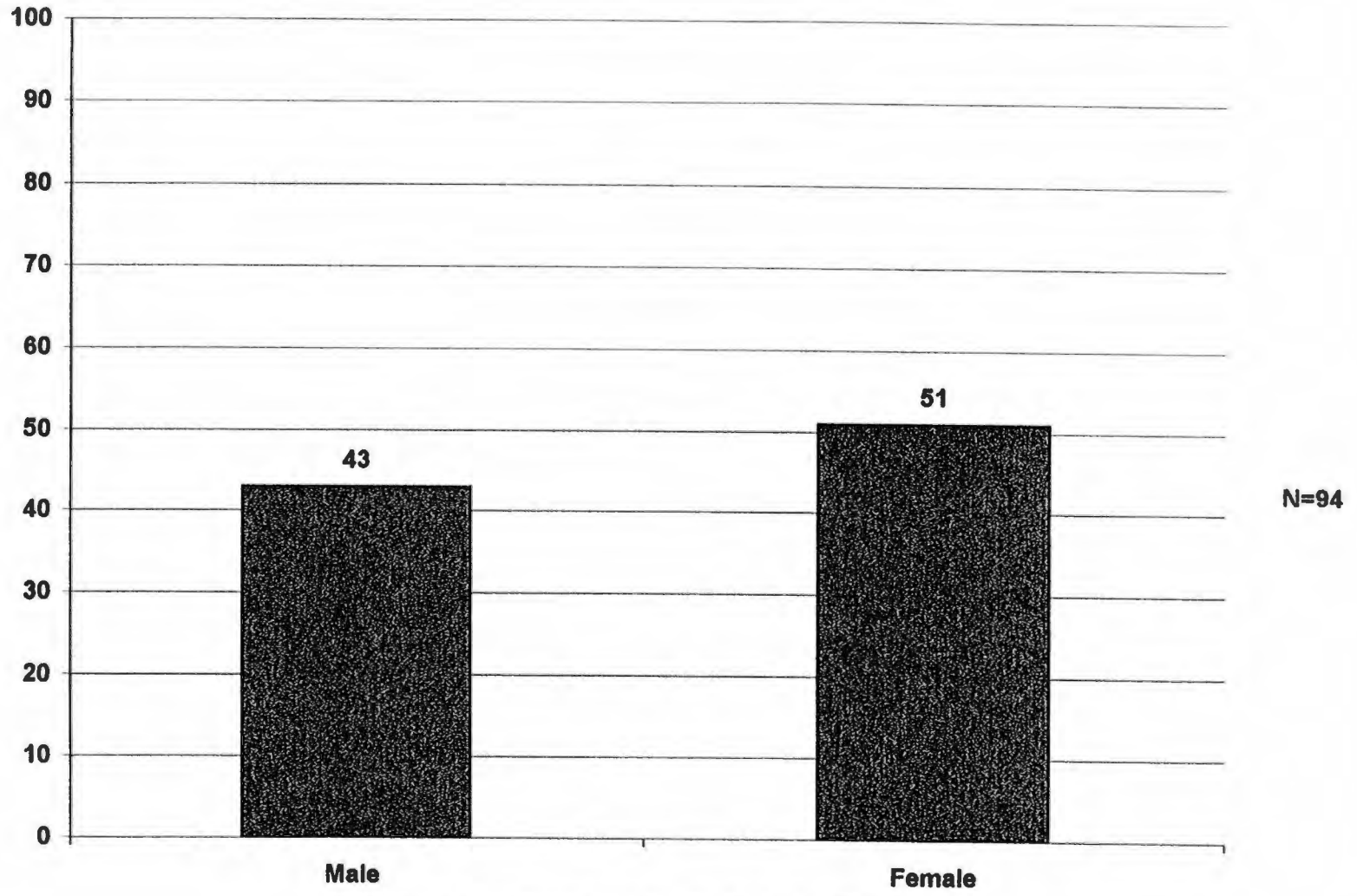


Figure 3. State University Students by Gender

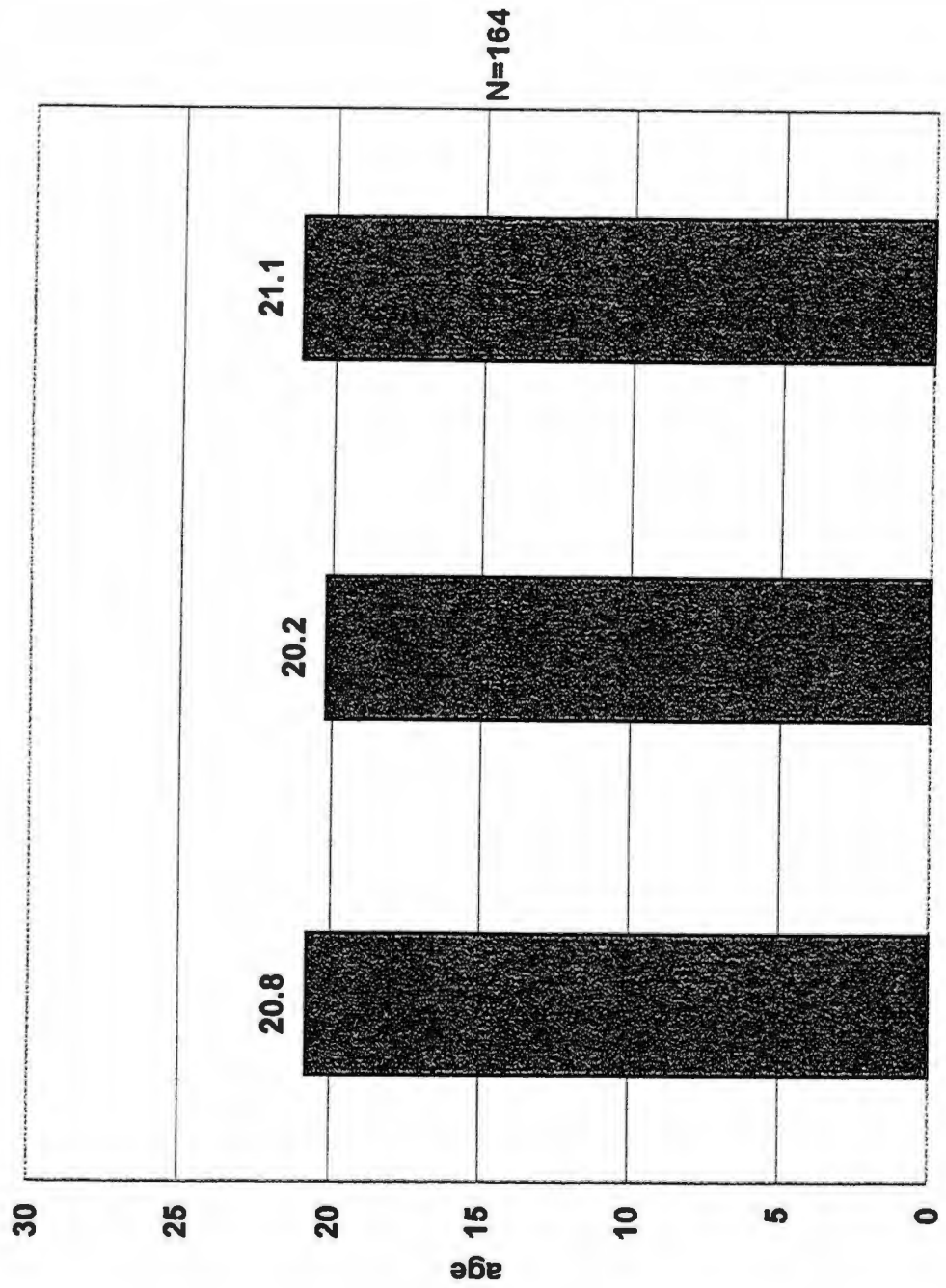


Figure 4. Total Participants, Seventh-day Adventist and State University Students by Age

APPENDIX D

GROUP SUMMARY REPORTS

Group Summary Report

February 6, 2000 Questionnaire: PRA

RESPONDENTS: All

DATA FILES:

Data file	Description	Number of records — Included	Skipped	Total	Date Created
NSD03	University of Florida	34	8	42	11/11/99
NSD05	SouthWest Texas State Univer.	31	4	35	11/11/99
NSDA01	University of Tennessee	29	9	38	11/11/99
SD02	Southern Adventist Collegedale	26	10	36	11/11/99
SDA04	Florida Hospital of Health.Sci	9	0	9	12/07/99
SDA06	Southwest Adventist Texas	35	12	47	11/18/99
	Number of records in 6 data files	164	43	207	

* GROUP SUMMARY *

1.	Sex	N valid: 164	N missing: 0	Cat #: 1				MALE n =	68	41.46% of valid resp.			
				Cat #: 2				FEMALE n =	96	58.54% of valid resp.			
2.	Age	N valid: 164	N missing: 0	Min: 18	Max: 29	Mean: 20.75	Std Dev: 2.07						
COMP	WellnessNow score — with Age & Sex breakdowns												
	Total Population:	N valid: 164	N missing: 0	Min: 14	Max: 100	Mean: 82.75	Std Dev: 21.95						
	BY SEX: MALE:	N valid: 68	N missing: 0	Min: 14	Max: 100	Mean: 75.59	Std Dev: 25.89						
	BY SEX: FEMALE:	N valid: 96	N missing: 0	Min: 37	Max: 100	Mean: 87.82	Std Dev: 16.92						
	BY AGE: 18 - 25 yrs:	N valid: 156	N missing: 0	Min: 14	Max: 100	Mean: 82.56	Std Dev: 22.32						
	BY AGE: 25 - 34 yrs:	N valid: 8	N missing: 0	Min: 64	Max: 100	Mean: 86.38	Std Dev: 12.02						
	BY AGE: 35 - 44 yrs:	N valid: 0	N missing: 0	Min: 0	Max: 0	Mean: 0.00	Std Dev: 0.00						
	BY AGE: 45 - 54 yrs:	N valid: 0	N missing: 0	Min: 0	Max: 0	Mean: 0.00	Std Dev: 0.00						
	BY AGE: 55 - 64 yrs:	N valid: 0	N missing: 0	Min: 0	Max: 0	Mean: 0.00	Std Dev: 0.00						
	BY AGE: 65 + yrs:	N valid: 0	N missing: 0	Min: 0	Max: 0	Mean: 0.00	Std Dev: 0.00						
COMP	Height (in inches) — with Age & Sex breakdowns												
	Total Population:	N valid: 164	N missing: 0	Min: 59	Max: 76	Mean: 67.49	Std Dev: 3.69						
	BY SEX: MALE:	N valid: 68	N missing: 0	Min: 61	Max: 76	Mean: 70.15	Std Dev: 2.90						
	BY SEX: FEMALE:	N valid: 96	N missing: 0	Min: 59	Max: 72	Mean: 65.60	Std Dev: 2.96						
	BY AGE: 18 - 25 yrs:	N valid: 156	N missing: 0	Min: 59	Max: 76	Mean: 67.49	Std Dev: 3.69						
	BY AGE: 25 - 34 yrs:	N valid: 8	N missing: 0	Min: 62	Max: 72	Mean: 67.38	Std Dev: 3.71						
	BY AGE: 35 - 44 yrs:	N valid: 0	N missing: 0	Min: 0	Max: 0	Mean: 0.00	Std Dev: 0.00						
	BY AGE: 45 - 54 yrs:	N valid: 0	N missing: 0	Min: 0	Max: 0	Mean: 0.00	Std Dev: 0.00						
	BY AGE: 55 - 64 yrs:	N valid: 0	N missing: 0	Min: 0	Max: 0	Mean: 0.00	Std Dev: 0.00						
	BY AGE: 65 + yrs:	N valid: 0	N missing: 0	Min: 0	Max: 0	Mean: 0.00	Std Dev: 0.00						
4.	Weight (no shoes) — with Age & Sex breakdowns												
	Total Population:	N valid: 164	N missing: 0	Min: 98	Max: 277	Mean: 149.55	Std Dev: 29.90						
	BY SEX: MALE:	N valid: 68	N missing: 0	Min: 115	Max: 277	Mean: 171.59	Std Dev: 29.66						
	BY SEX: FEMALE:	N valid: 96	N missing: 0	Min: 98	Max: 181	Mean: 133.94	Std Dev: 17.80						
	BY AGE: 18 - 25 yrs:	N valid: 156	N missing: 0	Min: 98	Max: 277	Mean: 149.65	Std Dev: 30.20						
	BY AGE: 25 - 34 yrs:	N valid: 8	N missing: 0	Min: 110	Max: 175	Mean: 147.63	Std Dev: 23.34						
	BY AGE: 35 - 44 yrs:	N valid: 0	N missing: 0	Min: 0	Max: 0	Mean: 0.00	Std Dev: 0.00						
	BY AGE: 45 - 54 yrs:	N valid: 0	N missing: 0	Min: 0	Max: 0	Mean: 0.00	Std Dev: 0.00						
	BY AGE: 55 - 64 yrs:	N valid: 0	N missing: 0	Min: 0	Max: 0	Mean: 0.00	Std Dev: 0.00						
	BY AGE: 65 + yrs:	N valid: 0	N missing: 0	Min: 0	Max: 0	Mean: 0.00	Std Dev: 0.00						

Group Summary Report

February 6, 2000 Questionnaire: PRA

5.	Body frame size	N valid: 135	N missing: 29	Cat # 1				SMALL n =	33	24.44% of valid resp.
				Cat # 2				MEDIUM n =	86	63.70% of valid resp.
				Cat # 3				LARGE n =	16	11.85% of valid resp.
COMP	Body mass index	N valid: 164	N missing: 0	Min: 15		Max 38		Mean: 22.43		Std Dev: 3.14	
COMP	Obesity	N valid: 164	N missing: 0	Cat # 1				NORMAL n =	122	74.39% of valid resp.
				Cat # 2				10%OVER n =	24	14.63% of valid resp.
				Cat # 3				20%OVER n =	18	10.98% of valid resp.
6.	Ever had diabetes	N valid: 158	N missing: 6	Cat # 1				YES n =	0	0.00% of valid resp.
				Cat # 2				NO n =	158	100.00% of valid resp.
7.	Blood pressure meds.	N valid: 162	N missing: 2	Cat # 1				YES n =	1	0.62% of valid resp.
				Cat # 2				NO n =	161	99.38% of valid resp.

8. Systolic BP — with Age & Sex breakdowns

	Total Population:	N valid: 62	N missing: 102	Min: 87		Max 164		Mean: 112.61		Std Dev: 14.86	
	BY SEX: MALE:	N valid: 23	N missing: 45	Min: 90		Max 148		Mean: 118.87		Std Dev: 13.06	
	BY SEX: FEMALE:	N valid: 39	N missing: 57	Min: 87		Max 164		Mean: 108.92		Std Dev: 14.62	
	BY AGE: 18 - 25 yrs:	N valid: 60	N missing: 96	Min: 87		Max 164		Mean: 112.47		Std Dev: 15.03	
	BY AGE: 25 - 34 yrs:	N valid: 2	N missing: 6	Min: 110		Max 124		Mean: 117.00		Std Dev: 7.00	
	BY AGE: 35 - 44 yrs:	N valid: 0	N missing: 0	Min: 0		Max 0		Mean: 0.00		Std Dev: 0.00	
	BY AGE: 45 - 54 yrs:	N valid: 0	N missing: 0	Min: 0		Max 0		Mean: 0.00		Std Dev: 0.00	
	BY AGE: 55 - 64 yrs:	N valid: 0	N missing: 0	Min: 0		Max 0		Mean: 0.00		Std Dev: 0.00	
	BY AGE: 65 + yrs:	N valid: 0	N missing: 0	Min: 0		Max 0		Mean: 0.00		Std Dev: 0.00	

Diastolic BP — with Age & Sex breakdowns

	Total Population:	N valid: 62	N missing: 102	Min: 40		Max 109		Mean: 70.69		Std Dev: 11.54	
	BY SEX: MALE:	N valid: 23	N missing: 45	Min: 58		Max 89		Mean: 74.78		Std Dev: 9.29	
	BY SEX: FEMALE:	N valid: 39	N missing: 57	Min: 40		Max 109		Mean: 68.28		Std Dev: 12.05	
	BY AGE: 18 - 25 yrs:	N valid: 60	N missing: 96	Min: 40		Max 109		Mean: 70.60		Std Dev: 11.70	
	BY AGE: 25 - 34 yrs:	N valid: 2	N missing: 6	Min: 70		Max 77		Mean: 73.50		Std Dev: 3.50	
	BY AGE: 35 - 44 yrs:	N valid: 0	N missing: 0	Min: 0		Max 0		Mean: 0.00		Std Dev: 0.00	
	BY AGE: 45 - 54 yrs:	N valid: 0	N missing: 0	Min: 0		Max 0		Mean: 0.00		Std Dev: 0.00	
	BY AGE: 55 - 64 yrs:	N valid: 0	N missing: 0	Min: 0		Max 0		Mean: 0.00		Std Dev: 0.00	
	BY AGE: 65 + yrs:	N valid: 0	N missing: 0	Min: 0		Max 0		Mean: 0.00		Std Dev: 0.00	
COMP	Blood Pressure	N valid: 164	N missing: 0	Cat # 1				OK (UNDER 140/90) n =	161	98.17% of valid resp.	
				Cat # 2				HIGH (140/90 & OVER) n =	3	1.83% of valid resp.	
9.	Blood pressure range	N valid: 102	N missing: 0	Cat # 1				HIGH n =	1	0.98% of valid resp.	
				Cat # 2				LOW OR NORMAL n =	79	77.45% of valid resp.	
				Cat # 3				DON'T KNOW n =	22	21.57% of valid resp.	

10. Total cholesterol — with Age & Sex breakdowns

	Total Population:	N valid: 15	N missing: 149	Min: 0		Max 220		Mean: 114.87		Std Dev: 76.59	
	BY SEX: MALE:	N valid: 8	N missing: 60	Min: 0		Max 198		Mean: 113.63		Std Dev: 70.55	
	BY SEX: FEMALE:	N valid: 7	N missing: 89	Min: 0		Max 220		Mean: 116.29		Std Dev: 82.92	
	BY AGE: 18 - 25 yrs:	N valid: 13	N missing: 143	Min: 0		Max 220		Mean: 124.85		Std Dev: 75.08	
	BY AGE: 25 - 34 yrs:	N valid: 2	N missing: 6	Min: 0		Max 100		Mean: 50.00		Std Dev: 50.00	
	BY AGE: 35 - 44 yrs:	N valid: 0	N missing: 0	Min: 0		Max 0		Mean: 0.00		Std Dev: 0.00	
	BY AGE: 45 - 54 yrs:	N valid: 0	N missing: 0	Min: 0		Max 0		Mean: 0.00		Std Dev: 0.00	
	BY AGE: 55 - 64 yrs:	N valid: 0	N missing: 0	Min: 0		Max 0		Mean: 0.00		Std Dev: 0.00	
	BY AGE: 65 + yrs:	N valid: 0	N missing: 0	Min: 0		Max 0		Mean: 0.00		Std Dev: 0.00	
COMP	Cholesterol	N valid: 11	N missing: 153	Cat # 1				UNDER 200 n =	10	90.91% of valid resp.	
				Cat # 2				200-239 n =	1	9.09% of valid resp.	
				Cat # 3				240+ n =	0	0.00% of valid resp.	

Group Summary Report

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11.	HDL cholesterol	N valid: 2	N missing: 162	Min: 45	Max: 48	Mean: 46.50	Std Dev: 1.50					
12.	Cigars per day	N valid: 163	N missing: 1	Cat # 1	NONE n = 159	97.55% of valid resp.						
				Cat # 2	1 PER DAY n = 1	0.61% of valid resp.						
				Cat # 3	2+ PER DAY n = 3	1.84% of valid resp.						
13.	Pipes per day	N valid: 160	N missing: 4	Cat # 1	NONE n = 160	100.00% of valid resp.						
				Cat # 2	1 PER DAY n = 0	0.00% of valid resp.						
				Cat # 3	2+ PER DAY n = 0	0.00% of valid resp.						
14.	Smokeless tobacco	N valid: 160	N missing: 4	Cat # 1	NONE n = 157	98.13% of valid resp.						
				Cat # 2	1 PER DAY n = 2	1.25% of valid resp.						
				Cat # 3	2+ PER DAY n = 1	0.63% of valid resp.						
COMP	Cigarette smoking	N valid: 164	N missing: 0	Cat # 1	NEVER n = 127	77.44% of valid resp.						
				Cat # 2	EX-SMOKER n = 18	10.98% of valid resp.						
				Cat # 3	CURRENT<20 n = 18	10.98% of valid resp.						
				Cat # 4	HEAVY 20+ n = 1	0.61% of valid resp.						
16.	Cigarettes a day — with Age & Sex breakdowns											
	Total Population:	N valid: 19	N missing: 0	Response: 0 or none	n = 1	5.26% of total group						
				: 1 or more	n = 18	94.74% of total group						
		For responses of 1 or more:		Min: 1	Max: 20	Mean: 6.00	Std Dev: 4.65					
	BY SEX: MALE:	N valid: 10	N missing: 0	Response: 0 or none	n = 1	10.00% of total group						
				: 1 or more	n = 9	90.00% of total group						
		For responses of 1 or more:		Min: 1	Max: 20	Mean: 7.78	Std Dev: 5.29					
	BY SEX: FEMALE:	N valid: 9	N missing: 0	Response: 0 or none	n = 0	0.00% of total group						
				: 1 or more	n = 9	100.00% of total group						
		For responses of 1 or more:		Min: 1	Max: 10	Mean: 4.22	Std Dev: 3.01					
	BY AGE: 18 - 25 yrs:	N valid: 18	N missing: 0	Response: 0 or none	n = 1	5.56% of total group						
				: 1 or more	n = 17	94.44% of total group						
		For responses of 1 or more:		Min: 1	Max: 20	Mean: 5.94	Std Dev: 4.78					
	BY AGE: 25 - 34 yrs:	N valid: 1	N missing: 0	Response: 0 or none	n = 0	0.00% of total group						
				: 1 or more	n = 1	100.00% of total group						
		For responses of 1 or more:		Min: 7	Max: 7	Mean: 7.00	Std Dev: 0.00					
	BY AGE: 35 - 44 yrs:	N valid: 0	N missing: 0	Response: 0 or none	n = 0	00% of total group						
				: 1 or more	n = 0	00% of total group						
		For responses of 1 or more:		Min: 0	Max: 0	Mean: 0.00	Std Dev: 0.00					
	BY AGE: 45 - 54 yrs:	N valid: 0	N missing: 0	Response: 0 or none	n = 0	00% of total group						
				: 1 or more	n = 0	00% of total group						
		For responses of 1 or more:		Min: 0	Max: 0	Mean: 0.00	Std Dev: 0.00					
	BY AGE: 55 - 64 yrs:	N valid: 0	N missing: 0	Response: 0 or none	n = 0	00% of total group						
				: 1 or more	n = 0	00% of total group						
		For responses of 1 or more:		Min: 0	Max: 0	Mean: 0.00	Std Dev: 0.00					
	BY AGE: 65 + yrs:	N valid: 0	N missing: 0	Response: 0 or none	n = 0	00% of total group						
				: 1 or more	n = 0	00% of total group						
		For responses of 1 or more:		Min: 0	Max: 0	Mean: 0.00	Std Dev: 0.00					
17a	Years since you quit	N valid: 18	N missing: 0	Response: 0 or none	n = 2	11.11% of total group						
				: 1 or more	n = 16	88.89% of total group						
		For responses of 1 or more:		Min: 1	Max: 9	Mean: 2.25	Std Dev: 2.08					

Group Summary Report

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17b	Cigarettes pre-quit	N valid: 18	N missing: 0	Response: 0 or none			n = 0		0.00% of total group				
				: 1 or more			n = 18		100.00% of total group				
		For responses of 1 or more:		Min: 1	Max: 20		Mean: 8.83		Std Dev: 5.26				
18a	Miles by car	N valid: 162	N missing: 2	Min: 0	Max: 50		Mean: 12.10		Std Dev: 8.58				
18b	Miles by motorcycle	N valid: 164	N missing: 0	Min: 0	Max: 6		Mean: 0.13		Std Dev: 0.75				
19.	Typical travel	N valid: 152	N missing: 12	Cat # 1	WALK	n = 44	28.95% of valid resp.						
				Cat # 2	BICYCLE	n = 2	1.32% of valid resp.						
				Cat # 3	MOTORCYCLE	n = 0	0.00% of valid resp.						
				Cat # 4	COMPACT CAR	n = 40	26.32% of valid resp.						
				Cat # 5	MID/FULL SIZE CAR	n = 46	30.26% of valid resp.						
				Cat # 6	TRUCK OR VAN	n = 19	12.50% of valid resp.						
				Cat # 7	BUS OR TRAIN	n = 1	0.66% of valid resp.						
				Cat # 8	MOSTLY STAY HOME	n = 0	0.00% of valid resp.						
20.	Seatbelt percent	N valid: 159	N missing: 1	Cat # 1	NEVER (0%)	n = 3	1.89% of valid resp.						
				Cat # 2	SELDOM (1-39%)	n = 7	4.40% of valid resp.						
				Cat # 3	SOMETIMES (40-79%)	n = 16	10.06% of valid resp.						
				Cat # 4	USUALLY (80-99%)	n = 42	26.42% of valid resp.						
				Cat # 5	ALWAYS (100%)	n = 91	57.23% of valid resp.						
21.	Average driving speed	N valid: 159	N missing: 1	Cat # 1	< 5 MPH OVER LIMIT	n = 39	24.53% of valid resp.						
				Cat # 2	6-10 MPH OVER LIMIT	n = 90	56.60% of valid resp.						
				Cat # 3	11-15 MPH OVER LIMIT	n = 24	15.09% of valid resp.						
				Cat # 4	15+ MPH OVER LIMIT	n = 6	3.77% of valid resp.						
22.	Drive after drinking	N valid: 157	N missing: 3	Response: 0 or none			n = 106		66.25% of total group				
				: 1 or more			n = 54		33.75% of total group				
		For responses of 1 or more:		Min: 1	Max: 40		Mean: 4.19		Std Dev: 5.95				
23.	Alcohol per week	N valid: 160	N missing: 4	Response: 0 or none			n = 82		50.00% of total group				
				: 1 or more			n = 82		50.00% of total group				
		For responses of 1 or more:		Min: 1	Max: 50		Mean: 9.37		Std Dev: 9.61				

23. Alcohol per week — with Age & Sex breakdowns

Total Population:	N valid: 160	N missing: 4	Min: 0	Max: 50	Mean: 4.80	Std Dev: 8.32	
BY SEX: MALE:	N valid: 66	N missing: 2	Min: 0	Max: 50	Mean: 8.05	Std Dev: 11.27	
BY SEX: FEMALE:	N valid: 94	N missing: 2	Min: 0	Max: 20	Mean: 2.52	Std Dev: 4.00	
BY AGE: 18 - 25 yrs:	N valid: 152	N missing: 4	Min: 0	Max: 50	Mean: 4.71	Std Dev: 8.24	
BY AGE: 25 - 34 yrs:	N valid: 8	N missing: 0	Min: 0	Max: 30	Mean: 6.50	Std Dev: 9.49	
BY AGE: 35 - 44 yrs:	N valid: 0	N missing: 0	Min: 0	Max: 0	Mean: 0.00	Std Dev: 0.00	
BY AGE: 45 - 54 yrs:	N valid: 0	N missing: 0	Min: 0	Max: 0	Mean: 0.00	Std Dev: 0.00	
BY AGE: 55 - 64 yrs:	N valid: 0	N missing: 0	Min: 0	Max: 0	Mean: 0.00	Std Dev: 0.00	
BY AGE: 65 + yrs:	N valid: 0	N missing: 0	Min: 0	Max: 0	Mean: 0.00	Std Dev: 0.00	

24.	Age at first period	N valid: 95	N missing: 1	Cat # 1	11 OR UNDER	n = 19	20.00% of valid resp.
				Cat # 2	12-13 YEARS OLD	n = 57	60.00% of valid resp.
				Cat # 3	14 OR OVER	n = 19	20.00% of valid resp.
25.	Age at first birth	N valid: 95	N missing: 1	Cat # 1	NO CHILDREN	n = 91	95.79% of valid resp.
				Cat # 2	UNDER 20	n = 1	1.05% of valid resp.
				Cat # 3	20-24	n = 3	3.16% of valid resp.
				Cat # 4	25-29	n = 0	0.00% of valid resp.
				Cat # 5	30 OR OVER	n = 0	0.00% of valid resp.

Group Summary Report

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26.	Years since Mammogram	N valid:	96	N missing:	0	Cat #	1	WITHIN 1 YEAR n =	8	8.33% of valid resp.
						Cat #	2	1 YEAR AGO n =	2	2.08% of valid resp.
						Cat #	3	2 YEARS AGO n =	1	1.04% of valid resp.
						Cat #	4	3 OR MORE YEARS AGO n =	1	1.04% of valid resp.
						Cat #	5	NEVER n =	84	87.50% of valid resp.
27.	Family breast cancer	N valid:	95	N missing:	1	Cat #	1	NONE n =	81	85.26% of valid resp.
						Cat #	2	ONE n =	6	6.32% of valid resp.
						Cat #	3	2 OR MORE n =	3	3.16% of valid resp.
						Cat #	4	DON'T KNOW n =	5	5.26% of valid resp.
28.	Hysterectomy	N valid:	94	N missing:	2	Cat #	1	YES n =	0	0.00% of valid resp.
						Cat #	2	NO n =	94	100.00% of valid resp.
29.	Years since pap smear	N valid:	96	N missing:	0	Cat #	1	WITHIN 1 YEAR n =	39	40.63% of valid resp.
						Cat #	2	1 YEAR AGO n =	9	9.38% of valid resp.
						Cat #	3	2 YEARS AGO n =	3	3.13% of valid resp.
						Cat #	4	3 OR MORE YEARS AGO n =	3	3.13% of valid resp.
						Cat #	5	NEVER n =	42	43.75% of valid resp.
30.	Breast self exam	N valid:	95	N missing:	1	Cat #	1	MONTHLY n =	16	16.84% of valid resp.
						Cat #	2	EVERY FEW MONTHS n =	41	43.16% of valid resp.
						Cat #	3	RARELY OR NEVER n =	38	40.00% of valid resp.
31.	Breast MD exam	N valid:	96	N missing:	0	Cat #	1	WITHIN 1 YEAR n =	44	45.83% of valid resp.
						Cat #	2	1 YEAR AGO n =	12	12.50% of valid resp.
						Cat #	3	2 YEARS AGO n =	3	3.13% of valid resp.
						Cat #	4	3 OR MORE YEARS AGO n =	7	7.29% of valid resp.
						Cat #	5	NEVER n =	30	31.25% of valid resp.
32.	Women: rectal exam	N valid:	93	N missing:	3	Cat #	1	WITHIN 1 YEAR n =	7	7.53% of valid resp.
						Cat #	2	1 YEAR AGO n =	3	3.23% of valid resp.
						Cat #	3	2 YEARS AGO n =	1	1.08% of valid resp.
						Cat #	4	3 OR MORE YEARS AGO n =	6	6.45% of valid resp.
						Cat #	5	NEVER n =	76	81.72% of valid resp.
33.	Men: rect/prost exam	N valid:	67	N missing:	1	Cat #	1	WITHIN 1 YEAR n =	2	2.99% of valid resp.
						Cat #	2	1 YEAR AGO n =	3	4.48% of valid resp.
						Cat #	3	2 YEARS AGO n =	3	4.48% of valid resp.
						Cat #	4	3 OR MORE YEARS AGO n =	8	11.94% of valid resp.
						Cat #	5	NEVER n =	51	76.12% of valid resp.
34.	Witness violence	N valid:	161	N missing:	3	Cat #	1	4 OR MORE TIMES n =	5	3.11% of valid resp.
						Cat #	2	2-3 TIMES n =	15	9.32% of valid resp.
						Cat #	3	ONCE OR NEVER n =	120	74.53% of valid resp.
						Cat #	4	NOT SURE n =	21	13.04% of valid resp.
35.	Overall health	N valid:	164	N missing:	0	Cat #	1	EXCELLENT n =	48	29.27% of valid resp.
						Cat #	2	GOOD n =	95	57.93% of valid resp.
						Cat #	3	FAIR n =	20	12.20% of valid resp.
						Cat #	4	POOR n =	1	0.61% of valid resp.
36.	Exercise/week	N valid:	146	N missing:	18	Cat #	1	LESS THAN ONCE/WEEK n =	6	4.11% of valid resp.
						Cat #	2	1 OR 2 TIMES A WEEK n =	45	30.82% of valid resp.
						Cat #	3	3+ TIMES A WEEK n =	95	65.07% of valid resp.
37.	Motorcycle helmet use	N valid:	7	N missing:	1	Cat #	1	75-100% OF THE TIME n =	6	85.71% of valid resp.
						Cat #	2	25-74% OF THE TIME n =	1	14.29% of valid resp.
						Cat #	3	<25% OF THE TIME n =	0	0.00% of valid resp.
						Cat #	4	DOESN'T APPLY TO ME n =	0	0.00% of valid resp.

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38.	High FIBER food daily	N valid: 157	N missing:	7	Cat #	1	YES n =	138	87.90% of valid resp.
					Cat #	2	NO n =	19	12.10% of valid resp.
39.	High FAT food daily	N valid: 154	N missing:	10	Cat #	1	YES n =	108	70.13% of valid resp.
					Cat #	2	NO n =	46	29.87% of valid resp.
40.	Life satisfaction	N valid: 137	N missing:	27	Cat #	1	MOSTLY SATISFIED n =	104	75.91% of valid resp.
					Cat #	2	PARTLY SATISFIED n =	28	20.44% of valid resp.
					Cat #	3	NOT SATISFIED n =	5	3.65% of valid resp.
41.	Personal losses	N valid: 163	N missing:	1	Cat #	1	ONE n =	45	27.61% of valid resp.
					Cat #	2	TWO OR MORE n =	16	9.82% of valid resp.
					Cat #	3	NONE n =	102	62.58% of valid resp.
42a	Racial group	N valid: 157	N missing:	7	Cat #	1	AMERICAN INDIAN n =	0	0.00% of valid resp.
					Cat #	2	ASIAN n =	7	4.46% of valid resp.
					Cat #	3	BLACK n =	8	5.10% of valid resp.
					Cat #	4	PACIFIC ISLANDER n =	2	1.27% of valid resp.
					Cat #	5	WHITE n =	125	79.62% of valid resp.
					Cat #	6	OTHER n =	15	9.55% of valid resp.
					Cat #	7	DON'T KNOW n =	0	0.00% of valid resp.
42b	Hispanic origin	N valid: 156	N missing:	8	Cat #	1	YES n =	12	7.69% of valid resp.
					Cat #	2	NO n =	144	92.31% of valid resp.
43.	Highest grade	N valid: 161	N missing:	3	Cat #	1	GRADE SCHOOL n =	0	0.00% of valid resp.
					Cat #	2	SOME HIGH SCHOOL n =	0	0.00% of valid resp.
					Cat #	3	HIGH SCHOOL GRADUATE n =	16	9.94% of valid resp.
					Cat #	4	SOME COLLEGE n =	134	83.23% of valid resp.
					Cat #	5	COLLEGE GRADUATE n =	10	6.21% of valid resp.
					Cat #	6	POST-GRADUATE n =	1	0.62% of valid resp.
44.	Occupation	N valid: 158	N missing:	6	Cat #	1	HEALTH n =	6	3.80% of valid resp.
					Cat #	2	MANAGER/EDUC./PROF. n =	2	1.27% of valid resp.
					Cat #	3	TECHNICAL/SALES n =	2	1.27% of valid resp.
					Cat #	4	LABORER n =	1	0.63% of valid resp.
					Cat #	5	STUDENT n =	141	89.24% of valid resp.
					Cat #	6	RETIRED n =	0	0.00% of valid resp.
					Cat #	7	HOMEMAKER n =	1	0.63% of valid resp.
					Cat #	8	SERVICE n =	4	2.53% of valid resp.
					Cat #	9	SKILLED CRAFTS n =	0	0.00% of valid resp.
					Cat #	10	UNEMPLOYED n =	0	0.00% of valid resp.
					Cat #	11	OTHER n =	1	0.63% of valid resp.
45.	Industry	N valid: 148	N missing:	16	Cat #	1	UTILITIES n =	0	0.00% of valid resp.
					Cat #	2	TRANSPORT n =	3	2.03% of valid resp.
					Cat #	3	FARM/FISH/FORESTRY n =	3	2.03% of valid resp.
					Cat #	4	SALES n =	19	12.84% of valid resp.
					Cat #	5	FINANCIAL n =	10	6.76% of valid resp.
					Cat #	6	MINING n =	0	0.00% of valid resp.
					Cat #	7	GOVERNMENT n =	7	4.73% of valid resp.
					Cat #	8	MANUFACTURE n =	2	1.35% of valid resp.
					Cat #	9	CONSTRUCTION n =	5	3.38% of valid resp.
					Cat #	10	OTHER n =	99	66.89% of valid resp.

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46.	Optional question	N valid:	0	N missing:	0	Cat #	1	ONE n =	0	0.00% of valid resp.
						Cat #	2	TWO n =	0	0.00% of valid resp.
						Cat #	3	THREE n =	0	0.00% of valid resp.
						Cat #	4	FOUR n =	0	0.00% of valid resp.
						Cat #	5	FIVE n =	0	0.00% of valid resp.
						Cat #	6	SIX n =	0	0.00% of valid resp.
						Cat #	7	SEVEN n =	0	0.00% of valid resp.
						Cat #	8	EIGHT n =	0	0.00% of valid resp.
						Cat #	9	NINE n =	0	0.00% of valid resp.
47.	Optional question	N valid:	0	N missing:	0	Cat #	1	ONE n =	0	0.00% of valid resp.
						Cat #	2	TWO n =	0	0.00% of valid resp.
						Cat #	3	THREE n =	0	0.00% of valid resp.
						Cat #	4	FOUR n =	0	0.00% of valid resp.
						Cat #	5	FIVE n =	0	0.00% of valid resp.
						Cat #	6	SIX n =	0	0.00% of valid resp.
						Cat #	7	SEVEN n =	0	0.00% of valid resp.
						Cat #	8	EIGHT n =	0	0.00% of valid resp.
						Cat #	9	NINE n =	0	0.00% of valid resp.

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RESPONDENTS: All

DATA FILES:

Data file	Description	Number of records — Included	Skipped	Total	Date Created
SD02	Southern Adventist Collegedale	26	10	36	11/11/99
SDA04	Florida Hospital of Health Sci	9	0	9	12/07/99
SDA06	Southwest Adventist Texas	35	12	47	11/18/99
	Number of records in 3 data files	70	22	92	

*** GROUP SUMMARY ***

1.	Sex	N valid:	70	N missing:	0	Cat #	1			MALE n =	25	35.71% of valid resp.	
						Cat #	2			FEMALE n =	45	64.29% of valid resp.	
2.	Age	N valid:	70	N missing:	0	Min:	18	Max:	27	Mean:	20.21	Std Dev:	1.97
COMP	WellnessNow score — with Age & Sex breakdowns												
	Total Population:	N valid:	70	N missing:	0	Min:	49	Max:	100	Mean:	94.14	Std Dev:	11.93
	BY SEX: MALE:	N valid:	25	N missing:	0	Min:	49	Max:	100	Mean:	92.64	Std Dev:	12.53
	BY SEX: FEMALE:	N valid:	45	N missing:	0	Min:	51	Max:	100	Mean:	94.98	Std Dev:	11.50
	BY AGE: 18 - 25 yrs:	N valid:	67	N missing:	0	Min:	49	Max:	100	Mean:	94.24	Std Dev:	11.98
	BY AGE: 25 - 34 yrs:	N valid:	3	N missing:	0	Min:	77	Max:	100	Mean:	92.00	Std Dev:	10.61
	BY AGE: 35 - 44 yrs:	N valid:	0	N missing:	0	Min:	0	Max:	0	Mean:	0.00	Std Dev:	0.00
	BY AGE: 45 - 54 yrs:	N valid:	0	N missing:	0	Min:	0	Max:	0	Mean:	0.00	Std Dev:	0.00
	BY AGE: 55 - 64 yrs:	N valid:	0	N missing:	0	Min:	0	Max:	0	Mean:	0.00	Std Dev:	0.00
	BY AGE: 65 + yrs:	N valid:	0	N missing:	0	Min:	0	Max:	0	Mean:	0.00	Std Dev:	0.00
COMP	Height (in inches) — with Age & Sex breakdowns												
	Total Population:	N valid:	70	N missing:	0	Min:	60	Max:	74	Mean:	67.30	Std Dev:	3.24
	BY SEX: MALE:	N valid:	25	N missing:	0	Min:	61	Max:	74	Mean:	69.52	Std Dev:	2.77
	BY SEX: FEMALE:	N valid:	45	N missing:	0	Min:	60	Max:	72	Mean:	66.07	Std Dev:	2.80
	BY AGE: 18 - 25 yrs:	N valid:	67	N missing:	0	Min:	60	Max:	74	Mean:	67.28	Std Dev:	3.26
	BY AGE: 25 - 34 yrs:	N valid:	3	N missing:	0	Min:	64	Max:	71	Mean:	67.67	Std Dev:	2.87
	BY AGE: 35 - 44 yrs:	N valid:	0	N missing:	0	Min:	0	Max:	0	Mean:	0.00	Std Dev:	0.00
	BY AGE: 45 - 54 yrs:	N valid:	0	N missing:	0	Min:	0	Max:	0	Mean:	0.00	Std Dev:	0.00
	BY AGE: 55 - 64 yrs:	N valid:	0	N missing:	0	Min:	0	Max:	0	Mean:	0.00	Std Dev:	0.00
	BY AGE: 65 + yrs:	N valid:	0	N missing:	0	Min:	0	Max:	0	Mean:	0.00	Std Dev:	0.00
4.	Weight (no-shoes) — with Age & Sex breakdowns												
	Total Population:	N valid:	70	N missing:	0	Min:	98	Max:	277	Mean:	144.83	Std Dev:	27.87
	BY SEX: MALE:	N valid:	25	N missing:	0	Min:	133	Max:	277	Mean:	163.60	Std Dev:	30.33
	BY SEX: FEMALE:	N valid:	45	N missing:	0	Min:	98	Max:	181	Mean:	134.40	Std Dev:	19.81
	BY AGE: 18 - 25 yrs:	N valid:	67	N missing:	0	Min:	98	Max:	277	Mean:	145.52	Std Dev:	27.90
	BY AGE: 25 - 34 yrs:	N valid:	3	N missing:	0	Min:	110	Max:	160	Mean:	129.33	Std Dev:	21.93
	BY AGE: 35 - 44 yrs:	N valid:	0	N missing:	0	Min:	0	Max:	0	Mean:	0.00	Std Dev:	0.00
	BY AGE: 45 - 54 yrs:	N valid:	0	N missing:	0	Min:	0	Max:	0	Mean:	0.00	Std Dev:	0.00
	BY AGE: 55 - 64 yrs:	N valid:	0	N missing:	0	Min:	0	Max:	0	Mean:	0.00	Std Dev:	0.00
	BY AGE: 65 + yrs:	N valid:	0	N missing:	0	Min:	0	Max:	0	Mean:	0.00	Std Dev:	0.00
5.	Body frame size	N valid:	54	N missing:	16	Cat #	1			SMALL n =	14	25.93% of valid resp.	
						Cat #	2			MEDIUM n =	37	68.52% of valid resp.	
						Cat #	3			LARGE n =	3	5.56% of valid resp.	
COMP	Body mass index	N valid:	70	N missing:	0	Min:	15	Max:	38	Mean:	21.84	Std Dev:	3.44

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COMP	Obesity	N valid: 70	N missing: 0	Cat # 1	NORMAL n =	58	82.86% of valid resp.
				Cat # 2	10%OVER n =	6	8.57% of valid resp.
				Cat # 3	20%OVER n =	6	8.57% of valid resp.
6.	Ever had diabetes	N valid: 69	N missing: 1	Cat # 1	YES n =	0	0.00% of valid resp.
				Cat # 2	NO n =	69	100.00% of valid resp.
7.	Blood pressure meds.	N valid: 68	N missing: 2	Cat # 1	YES n =	0	0.00% of valid resp.
				Cat # 2	NO n =	68	100.00% of valid resp.

8. Systolic BP — with Age & Sex breakdowns

Total Population:	N valid: 40	N missing: 30	Min: 87	Max: 164	Mean: 109.68	Std Dev: 15.85
BY SEX: MALE:	N valid: 15	N missing: 10	Min: 90	Max: 148	Mean: 117.13	Std Dev: 14.39
BY SEX: FEMALE:	N valid: 25	N missing: 20	Min: 87	Max: 164	Mean: 105.20	Std Dev: 14.97
BY AGE: 18 - 25 yrs:	N valid: 39	N missing: 28	Min: 87	Max: 164	Mean: 109.67	Std Dev: 16.05
BY AGE: 25 - 34 yrs:	N valid: 1	N missing: 2	Min: 110	Max: 110	Mean: 110.00	Std Dev: 0.00
BY AGE: 35 - 44 yrs:	N valid: 0	N missing: 0	Min: 0	Max: 0	Mean: 0.00	Std Dev: 0.00
BY AGE: 45 - 54 yrs:	N valid: 0	N missing: 0	Min: 0	Max: 0	Mean: 0.00	Std Dev: 0.00
BY AGE: 55 - 64 yrs:	N valid: 0	N missing: 0	Min: 0	Max: 0	Mean: 0.00	Std Dev: 0.00
BY AGE: 65 + yrs:	N valid: 0	N missing: 0	Min: 0	Max: 0	Mean: 0.00	Std Dev: 0.00

Diastolic BP — with Age & Sex breakdowns

Total Population:	N valid: 40	N missing: 30	Min: 40	Max: 109	Mean: 68.80	Std Dev: 12.29
BY SEX: MALE:	N valid: 15	N missing: 10	Min: 58	Max: 88	Mean: 72.87	Std Dev: 9.53
BY SEX: FEMALE:	N valid: 25	N missing: 20	Min: 40	Max: 109	Mean: 66.36	Std Dev: 13.09
BY AGE: 18 - 25 yrs:	N valid: 39	N missing: 28	Min: 40	Max: 109	Mean: 68.77	Std Dev: 12.44
BY AGE: 25 - 34 yrs:	N valid: 1	N missing: 2	Min: 70	Max: 70	Mean: 70.00	Std Dev: 0.00
BY AGE: 35 - 44 yrs:	N valid: 0	N missing: 0	Min: 0	Max: 0	Mean: 0.00	Std Dev: 0.00
BY AGE: 45 - 54 yrs:	N valid: 0	N missing: 0	Min: 0	Max: 0	Mean: 0.00	Std Dev: 0.00
BY AGE: 55 - 64 yrs:	N valid: 0	N missing: 0	Min: 0	Max: 0	Mean: 0.00	Std Dev: 0.00
BY AGE: 65 + yrs:	N valid: 0	N missing: 0	Min: 0	Max: 0	Mean: 0.00	Std Dev: 0.00

COMP	Blood Pressure	N valid: 70	N missing: 0	Cat # 1	OK (UNDER 140/90) n =	68	97.14% of valid resp.
				Cat # 2	HIGH (140/90 & OVER) n =	2	2.86% of valid resp.
9.	Blood pressure range	N valid: 30	N missing: 0	Cat # 1	HIGH n =	0	0.00% of valid resp.
				Cat # 2	LOW OR NORMAL n =	26	86.67% of valid resp.
				Cat # 3	DON'T KNOW n =	4	13.33% of valid resp.

10. Total cholesterol — with Age & Sex breakdowns

Total Population:	N valid: 6	N missing: 64	Min: 0	Max: 150	Mean: 78.17	Std Dev: 57.79
BY SEX: MALE:	N valid: 3	N missing: 22	Min: 0	Max: 150	Mean: 83.00	Std Dev: 62.27
BY SEX: FEMALE:	N valid: 3	N missing: 42	Min: 0	Max: 120	Mean: 73.33	Std Dev: 52.49
BY AGE: 18 - 25 yrs:	N valid: 5	N missing: 62	Min: 0	Max: 150	Mean: 73.80	Std Dev: 62.40
BY AGE: 25 - 34 yrs:	N valid: 1	N missing: 2	Min: 100	Max: 100	Mean: 100.00	Std Dev: 0.00
BY AGE: 35 - 44 yrs:	N valid: 0	N missing: 0	Min: 0	Max: 0	Mean: 0.00	Std Dev: 0.00
BY AGE: 45 - 54 yrs:	N valid: 0	N missing: 0	Min: 0	Max: 0	Mean: 0.00	Std Dev: 0.00
BY AGE: 55 - 64 yrs:	N valid: 0	N missing: 0	Min: 0	Max: 0	Mean: 0.00	Std Dev: 0.00
BY AGE: 65 + yrs:	N valid: 0	N missing: 0	Min: 0	Max: 0	Mean: 0.00	Std Dev: 0.00

COMP	Cholesterol	N valid: 4	N missing: 66	Cat # 1	UNDER 200 n =	4	100.00% of valid resp.
				Cat # 2	200-239 n =	0	0.00% of valid resp.
				Cat # 3	240+ n =	0	0.00% of valid resp.

11.	HDL cholesterol	N valid: 2	N missing: 68	Min: 45	Max: 48	Mean: 46.50	Std Dev: 1.50

12.	Cigars per day	N valid: 70	N missing: 0	Cat # 1	NONE n =	70	100.00% of valid resp.
				Cat # 2	1 PER DAY n =	0	0.00% of valid resp.
				Cat # 3	2+ PER DAY n =	0	0.00% of valid resp.

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13.	Pipes per day	N valid: 67	N missing: 3	Cat # 1	NONE	n =	67	100.00% of valid resp.
				Cat # 2	1 PER DAY	n =	0	0.00% of valid resp.
				Cat # 3	2+ PER DAY	n =	0	0.00% of valid resp.
14.	Smokeless tobacco	N valid: 68	N missing: 2	Cat # 1	NONE	n =	67	98.53% of valid resp.
				Cat # 2	1 PER DAY	n =	1	1.47% of valid resp.
				Cat # 3	2+ PER DAY	n =	0	0.00% of valid resp.
COMP	Cigarette smoking	N valid: 70	N missing: 0	Cat # 1	NEVER	n =	65	92.86% of valid resp.
				Cat # 2	EX-SMOKER	n =	3	4.29% of valid resp.
				Cat # 3	CURRENT<20	n =	2	2.86% of valid resp.
				Cat # 4	HEAVY:20+	n =	0	0.00% of valid resp.

16. Cigarettes a day — with Age & Sex breakdowns

Total Population:	N valid: 2	N missing: 0	Response: 0 or none	n =	0				0.00% of total group
			: 1 or more	n =	2				100.00% of total group
	For responses of 1 or more:		Min: 2	Max: 7		Mean: 4.50		Std Dev: 2.50	
BY SEX: MALE:	N valid: 0	N missing: 0	Response: 0 or none	n =	0				00% of total group
			: 1 or more	n =	0				00% of total group
	For responses of 1 or more:		Min: 0	Max: 0		Mean: 0.00		Std Dev: 0.00	
BY SEX: FEMALE:	N valid: 2	N missing: 0	Response: 0 or none	n =	0				0.00% of total group
			: 1 or more	n =	2				100.00% of total group
	For responses of 1 or more:		Min: 2	Max: 7		Mean: 4.50		Std Dev: 2.50	
BY AGE: 18 - 25 yrs:	N valid: 1	N missing: 0	Response: 0 or none	n =	0				0.00% of total group
			: 1 or more	n =	1				100.00% of total group
	For responses of 1 or more:		Min: 2	Max: 2		Mean: 2.00		Std Dev: 0.00	
BY AGE: 25 - 34 yrs:	N valid: 1	N missing: 0	Response: 0 or none	n =	0				0.00% of total group
			: 1 or more	n =	1				100.00% of total group
	For responses of 1 or more:		Min: 7	Max: 7		Mean: 7.00		Std Dev: 0.00	
BY AGE: 35 - 44 yrs:	N valid: 0	N missing: 0	Response: 0 or none	n =	0				00% of total group
			: 1 or more	n =	0				00% of total group
	For responses of 1 or more:		Min: 0	Max: 0		Mean: 0.00		Std Dev: 0.00	
BY AGE: 45 - 54 yrs:	N valid: 0	N missing: 0	Response: 0 or none	n =	0				00% of total group
			: 1 or more	n =	0				00% of total group
	For responses of 1 or more:		Min: 0	Max: 0		Mean: 0.00		Std Dev: 0.00	
BY AGE: 55 - 64 yrs:	N valid: 0	N missing: 0	Response: 0 or none	n =	0				00% of total group
			: 1 or more	n =	0				00% of total group
	For responses of 1 or more:		Min: 0	Max: 0		Mean: 0.00		Std Dev: 0.00	
BY AGE: 65 + yrs:	N valid: 0	N missing: 0	Response: 0 or none	n =	0				00% of total group
			: 1 or more	n =	0				00% of total group
	For responses of 1 or more:		Min: 0	Max: 0		Mean: 0.00		Std Dev: 0.00	
17a Years since you quit	N valid: 3	N missing: 0	Response: 0 or none	n =	1				33.33% of total group
			: 1 or more	n =	2				66.67% of total group
	For responses of 1 or more:		Min: 1	Max: 2		Mean: 1.50		Std Dev: 0.50	
17b Cigarettes pre-quit	N valid: 3	N missing: 0	Response: 0 or none	n =	0				0.00% of total group
			: 1 or more	n =	3				100.00% of total group
	For responses of 1 or more:		Min: 3	Max: 20		Mean: 11.00		Std Dev: 6.98	
18a Miles by car	N valid: 69	N missing: 1	Min: 0	Max: 35		Mean: 10.52		Std Dev: 7.81	
18b Miles by motorcycle	N valid: 70	N missing: 0	Min: 0	Max: 6		Mean: 0.23		Std Dev: 0.96	

Group Summary Report

February 6, 2000 Questionnaire: PRA

19.	Typical travel	N valid: 66	N missing: 4	Cat # 1	WALK	n =	28	42.42% of valid resp.
				Cat # 2	BICYCLE	n =	1	1.52% of valid resp.
				Cat # 3	MOTORCYCLE	n =	0	0.00% of valid resp.
				Cat # 4	COMPACT CAR	n =	11	16.67% of valid resp.
				Cat # 5	MID/FULL SIZE CAR	n =	21	31.82% of valid resp.
				Cat # 6	TRUCK OR VAN	n =	5	7.58% of valid resp.
				Cat # 7	BUS OR TRAIN	n =	0	0.00% of valid resp.
				Cat # 8	MOSTLY STAY HOME	n =	0	0.00% of valid resp.
20.	Seatbelt percent	N valid: 67	N missing: 0	Cat # 1	NEVER (0%)	n =	0	0.00% of valid resp.
				Cat # 2	SELDOM (1-39%)	n =	0	0.00% of valid resp.
				Cat # 3	SOMETIMES (40-79%)	n =	1	1.49% of valid resp.
				Cat # 4	USUALLY (80-99%)	n =	22	32.84% of valid resp.
				Cat # 5	ALWAYS (100%)	n =	44	65.67% of valid resp.
21.	Average driving speed	N valid: 66	N missing: 1	Cat # 1	< 5 MPH OVER LIMIT	n =	23	34.85% of valid resp.
				Cat # 2	6-10 MPH OVER LIMIT	n =	34	51.52% of valid resp.
				Cat # 3	11-15 MPH OVER LIMIT	n =	7	10.61% of valid resp.
				Cat # 4	15+ MPH OVER LIMIT	n =	2	3.03% of valid resp.
22.	Drive after drinking	N valid: 67	N missing: 0	Response: 0 or none		n =	61	91.04% of total group
				: 1 or more		n =	6	8.96% of total group
		For responses of 1 or more:		Min: 1	Max: 5	Mean:	2.17	Std Dev: 1.34
23.	Alcohol per week	N valid: 67	N missing: 3	Response: 0 or none		n =	63	90.00% of total group
				: 1 or more		n =	7	10.00% of total group
		For responses of 1 or more:		Min: 1	Max: 5	Mean:	2.71	Std Dev: 1.16

23. Alcohol per week — with Age & Sex breakdowns

Total Population:	N valid: 67	N missing: 3	Min: 0	Max: 5	Mean: 0.28	Std Dev: 0.91
BY SEX: MALE:	N valid: 23	N missing: 2	Min: 0	Max: 3	Mean: 0.22	Std Dev: 0.72
BY SEX: FEMALE:	N valid: 44	N missing: 1	Min: 0	Max: 5	Mean: 0.32	Std Dev: 0.99
BY AGE: 18 - 25 yrs:	N valid: 64	N missing: 3	Min: 0	Max: 5	Mean: 0.22	Std Dev: 0.84
BY AGE: 25 - 34 yrs:	N valid: 3	N missing: 0	Min: 0	Max: 3	Mean: 1.67	Std Dev: 1.25
BY AGE: 35 - 44 yrs:	N valid: 0	N missing: 0	Min: 0	Max: 0	Mean: 0.00	Std Dev: 0.00
BY AGE: 45 - 54 yrs:	N valid: 0	N missing: 0	Min: 0	Max: 0	Mean: 0.00	Std Dev: 0.00
BY AGE: 55 - 64 yrs:	N valid: 0	N missing: 0	Min: 0	Max: 0	Mean: 0.00	Std Dev: 0.00
BY AGE: 65 + yrs:	N valid: 0	N missing: 0	Min: 0	Max: 0	Mean: 0.00	Std Dev: 0.00

24.	Age at first period	N valid: 45	N missing: 0	Cat # 1	11 OR UNDER	n =	7	15.56% of valid resp.
				Cat # 2	12-13 YEARS OLD	n =	29	64.44% of valid resp.
				Cat # 3	14 OR OVER	n =	9	20.00% of valid resp.
25.	Age at first birth	N valid: 44	N missing: 1	Cat # 1	NO CHILDREN	n =	41	93.18% of valid resp.
				Cat # 2	UNDER 20	n =	1	2.27% of valid resp.
				Cat # 3	20-24	n =	2	4.55% of valid resp.
				Cat # 4	25-29	n =	0	0.00% of valid resp.
				Cat # 5	30 OR OVER	n =	0	0.00% of valid resp.
26.	Years since Mammogram	N valid: 45	N missing: 0	Cat # 1	WITHIN 1 YEAR	n =	0	0.00% of valid resp.
				Cat # 2	1 YEAR AGO	n =	0	0.00% of valid resp.
				Cat # 3	2 YEARS AGO	n =	1	2.22% of valid resp.
				Cat # 4	3 OR MORE YEARS AGO	n =	1	2.22% of valid resp.
				Cat # 5	NEVER	n =	43	95.56% of valid resp.
27.	Family breast cancer	N valid: 44	N missing: 1	Cat # 1	NONE	n =	40	90.91% of valid resp.
				Cat # 2	ONE	n =	2	4.55% of valid resp.
				Cat # 3	2 OR MORE	n =	1	2.27% of valid resp.
				Cat # 4	DON'T KNOW	n =	1	2.27% of valid resp.

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28.	Hysterectomy	N valid:	45	N missing:	0	Cat #	1	YES n =	0	0.00% of valid resp.
						Cat #	2	NO n =	45	100.00% of valid resp.
29.	Years since pap smear	N valid:	45	N missing:	0	Cat #	1	WITHIN 1 YEAR n =	8	17.78% of valid resp.
						Cat #	2	1 YEAR AGO n =	2	4.44% of valid resp.
						Cat #	3	2 YEARS AGO n =	3	6.67% of valid resp.
						Cat #	4	3 OR MORE YEARS AGO n =	1	2.22% of valid resp.
						Cat #	5	NEVER n =	31	68.89% of valid resp.
30.	Breast self exam	N valid:	45	N missing:	0	Cat #	1	MONTHLY n =	9	20.00% of valid resp.
						Cat #	2	EVERY FEW MONTHS n =	18	40.00% of valid resp.
						Cat #	3	RARELY OR NEVER n =	18	40.00% of valid resp.
31.	Breast MD exam	N valid:	45	N missing:	0	Cat #	1	WITHIN 1 YEAR n =	14	31.11% of valid resp.
						Cat #	2	1 YEAR AGO n =	2	4.44% of valid resp.
						Cat #	3	2 YEARS AGO n =	3	6.67% of valid resp.
						Cat #	4	3 OR MORE YEARS AGO n =	5	11.11% of valid resp.
						Cat #	5	NEVER n =	21	46.67% of valid resp.
32.	Women: rectal exam	N valid:	45	N missing:	0	Cat #	1	WITHIN 1 YEAR n =	1	2.22% of valid resp.
						Cat #	2	1 YEAR AGO n =	2	4.44% of valid resp.
						Cat #	3	2 YEARS AGO n =	1	2.22% of valid resp.
						Cat #	4	3 OR MORE YEARS AGO n =	5	11.11% of valid resp.
						Cat #	5	NEVER n =	36	80.00% of valid resp.
33.	Men: rect/prost exam	N valid:	25	N missing:	0	Cat #	1	WITHIN 1 YEAR n =	1	4.00% of valid resp.
						Cat #	2	1 YEAR AGO n =	0	0.00% of valid resp.
						Cat #	3	2 YEARS AGO n =	1	4.00% of valid resp.
						Cat #	4	3 OR MORE YEARS AGO n =	4	16.00% of valid resp.
						Cat #	5	NEVER n =	19	76.00% of valid resp.
34.	Witness violence	N valid:	69	N missing:	1	Cat #	1	4 OR MORE TIMES n =	0	0.00% of valid resp.
						Cat #	2	2-3 TIMES n =	5	7.25% of valid resp.
						Cat #	3	ONCE OR NEVER n =	55	79.71% of valid resp.
						Cat #	4	NOT SURE n =	9	13.04% of valid resp.
35.	Overall health	N valid:	70	N missing:	0	Cat #	1	EXCELLENT n =	24	34.29% of valid resp.
						Cat #	2	GOOD n =	37	52.86% of valid resp.
						Cat #	3	FAIR n =	9	12.86% of valid resp.
						Cat #	4	POOR n =	0	0.00% of valid resp.
36.	Exercise/week	N valid:	63	N missing:	7	Cat #	1	LESS THAN ONCE/WEEK n =	1	1.59% of valid resp.
						Cat #	2	1 OR 2 TIMES A WEEK n =	16	25.40% of valid resp.
						Cat #	3	3+ TIMES A WEEK n =	46	73.02% of valid resp.
37.	Motorcycle helmet use	N valid:	6	N missing:	0	Cat #	1	75-100% OF THE TIME n =	5	83.33% of valid resp.
						Cat #	2	25-74% OF THE TIME n =	1	16.67% of valid resp.
						Cat #	3	<25% OF THE TIME n =	0	0.00% of valid resp.
						Cat #	4	DOESN'T APPLY TO ME n =	0	0.00% of valid resp.
38.	High FIBER food daily	N valid:	68	N missing:	2	Cat #	1	YES n =	64	94.12% of valid resp.
						Cat #	2	NO n =	4	5.88% of valid resp.
39.	High FAT food daily	N valid:	68	N missing:	2	Cat #	1	YES n =	46	67.65% of valid resp.
						Cat #	2	NO n =	22	32.35% of valid resp.
40.	Life satisfaction	N valid:	60	N missing:	10	Cat #	1	MOSTLY SATISFIED n =	44	73.33% of valid resp.
						Cat #	2	PARTLY SATISFIED n =	14	23.33% of valid resp.
						Cat #	3	NOT SATISFIED n =	2	3.33% of valid resp.

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41.	Personal losses	N valid:	69	N missing:	1	Cat #	1	ONE n =	19	27.54% of valid resp.
						Cat #	2	TWO OR MORE n =	7	10.14% of valid resp.
						Cat #	3	NONE n =	43	62.32% of valid resp.
42a	Racial group	N valid:	65	N missing:	5	Cat #	1	AMERICAN INDIAN n =	0	0.00% of valid resp.
						Cat #	2	ASIAN n =	4	6.15% of valid resp.
						Cat #	3	BLACK n =	5	7.69% of valid resp.
						Cat #	4	PACIFIC ISLANDER n =	1	1.54% of valid resp.
						Cat #	5	WHITE n =	50	76.92% of valid resp.
						Cat #	6	OTHER n =	5	7.69% of valid resp.
						Cat #	7	DON'T KNOW n =	0	0.00% of valid resp.
42b	Hispanic origin	N valid:	65	N missing:	5	Cat #	1	YES n =	3	4.62% of valid resp.
						Cat #	2	NO n =	62	95.38% of valid resp.
43.	Highest grade	N valid:	68	N missing:	2	Cat #	1	GRADE SCHOOL n =	0	0.00% of valid resp.
						Cat #	2	SOME HIGH SCHOOL n =	0	0.00% of valid resp.
						Cat #	3	HIGH SCHOOL GRADUATE n =	11	16.18% of valid resp.
						Cat #	4	SOME COLLEGE n =	52	76.47% of valid resp.
						Cat #	5	COLLEGE GRADUATE n =	4	5.88% of valid resp.
						Cat #	6	POST-GRADUATE n =	1	1.47% of valid resp.
44.	Occupation	N valid:	69	N missing:	1	Cat #	1	HEALTH n =	4	5.80% of valid resp.
						Cat #	2	MANAGER/EDUC./PROF. n =	0	0.00% of valid resp.
						Cat #	3	TECHNICAL/SALES n =	1	1.45% of valid resp.
						Cat #	4	LABORER n =	0	0.00% of valid resp.
						Cat #	5	STUDENT n =	63	91.30% of valid resp.
						Cat #	6	RETIRED n =	0	0.00% of valid resp.
						Cat #	7	HOMEMAKER n =	0	0.00% of valid resp.
						Cat #	8	SERVICE n =	1	1.45% of valid resp.
						Cat #	9	SKILLED CRAFTS n =	0	0.00% of valid resp.
						Cat #	10	UNEMPLOYED n =	0	0.00% of valid resp.
						Cat #	11	OTHER n =	0	0.00% of valid resp.
45.	Industry	N valid:	63	N missing:	7	Cat #	1	UTILITIES n =	0	0.00% of valid resp.
						Cat #	2	TRANSPORT n =	1	1.59% of valid resp.
						Cat #	3	FARM/FISH/FORESTRY n =	0	0.00% of valid resp.
						Cat #	4	SALES n =	7	11.11% of valid resp.
						Cat #	5	FINANCIAL n =	3	4.76% of valid resp.
						Cat #	6	MINING n =	0	0.00% of valid resp.
						Cat #	7	GOVERNMENT n =	2	3.17% of valid resp.
						Cat #	8	MANUFACTURE n =	2	3.17% of valid resp.
						Cat #	9	CONSTRUCTION n =	3	4.76% of valid resp.
						Cat #	10	OTHER n =	45	71.43% of valid resp.
46.	Optional question	N valid:	0	N missing:	0	Cat #	1	ONE n =	0	0.00% of valid resp.
						Cat #	2	TWO n =	0	0.00% of valid resp.
						Cat #	3	THREE n =	0	0.00% of valid resp.
						Cat #	4	FOUR n =	0	0.00% of valid resp.
						Cat #	5	FIVE n =	0	0.00% of valid resp.
						Cat #	6	SIX n =	0	0.00% of valid resp.
						Cat #	7	SEVEN n =	0	0.00% of valid resp.
						Cat #	8	EIGHT n =	0	0.00% of valid resp.
						Cat #	9	NINE n =	0	0.00% of valid resp.

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47.	Optional question	N valid:	0	N missing:	0	Cat #	1	ONE n =	0	0.00% of valid resp.
						Cat #	2	TWO n =	0	0.00% of valid resp.
						Cat #	3	THREE n =	0	0.00% of valid resp.
						Cat #	4	FOUR n =	0	0.00% of valid resp.
						Cat #	5	FIVE n =	0	0.00% of valid resp.
						Cat #	6	SIX n =	0	0.00% of valid resp.
						Cat #	7	SEVEN n =	0	0.00% of valid resp.
						Cat #	8	EIGHT n =	0	0.00% of valid resp.
						Cat #	9	NINE n =	0	0.00% of valid resp.

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RESPONDENTS: All

DATA FILES:

Data file	Description	Number of records — Included	Skipped	Total	Date Created
NSD03	University of Florida	34	8	42	11/11/99
NSD05	SouthWest Texas State Univer.	31	4	35	11/11/99
NSDA01	University of Tennessee	29	9	38	11/11/99
	Number of records in 3 data files	94	21	115	

*** GROUP SUMMARY ***

1.	Sex	N valid:	94	N missing:	0	Cat #	1			MALE n =	43	45.74% of valid resp.	
						Cat #	2			FEMALE n =	51	54.26% of valid resp.	
2.	Age	N valid:	94	N missing:	0	Min:	18	Max:	29	Mean:	21.15	Std Dev:	2.05
COMP	WellnessNow score — with Age & Sex breakdowns												
	Total Population:	N valid:	94	N missing:	0	Min:	14	Max:	100	Mean:	74.27	Std Dev:	23.79
	BY SEX: MALE:	N valid:	43	N missing:	0	Min:	14	Max:	100	Mean:	65.67	Std Dev:	26.48
	BY SEX: FEMALE:	N valid:	51	N missing:	0	Min:	37	Max:	100	Mean:	81.51	Std Dev:	18.36
	BY AGE: 18 - 25 yrs:	N valid:	89	N missing:	0	Min:	14	Max:	100	Mean:	73.76	Std Dev:	24.20
	BY AGE: 25 - 34 yrs:	N valid:	5	N missing:	0	Min:	64	Max:	98	Mean:	83.00	Std Dev:	11.54
	BY AGE: 35 - 44 yrs:	N valid:	0	N missing:	0	Min:	0	Max:	0	Mean:	0.00	Std Dev:	0.00
	BY AGE: 45 - 54 yrs:	N valid:	0	N missing:	0	Min:	0	Max:	0	Mean:	0.00	Std Dev:	0.00
	BY AGE: 55 - 64 yrs:	N valid:	0	N missing:	0	Min:	0	Max:	0	Mean:	0.00	Std Dev:	0.00
	BY AGE: 65 + yrs:	N valid:	0	N missing:	0	Min:	0	Max:	0	Mean:	0.00	Std Dev:	0.00
COMP	Height (in inches) — with Age & Sex breakdowns												
	Total Population:	N valid:	94	N missing:	0	Min:	59	Max:	76	Mean:	67.63	Std Dev:	3.98
	BY SEX: MALE:	N valid:	43	N missing:	0	Min:	63	Max:	76	Mean:	70.51	Std Dev:	2.91
	BY SEX: FEMALE:	N valid:	51	N missing:	0	Min:	59	Max:	72	Mean:	65.20	Std Dev:	3.03
	BY AGE: 18 - 25 yrs:	N valid:	89	N missing:	0	Min:	59	Max:	76	Mean:	67.65	Std Dev:	3.97
	BY AGE: 25 - 34 yrs:	N valid:	5	N missing:	0	Min:	62	Max:	72	Mean:	67.20	Std Dev:	4.12
	BY AGE: 35 - 44 yrs:	N valid:	0	N missing:	0	Min:	0	Max:	0	Mean:	0.00	Std Dev:	0.00
	BY AGE: 45 - 54 yrs:	N valid:	0	N missing:	0	Min:	0	Max:	0	Mean:	0.00	Std Dev:	0.00
	BY AGE: 55 - 64 yrs:	N valid:	0	N missing:	0	Min:	0	Max:	0	Mean:	0.00	Std Dev:	0.00
	BY AGE: 65 + yrs:	N valid:	0	N missing:	0	Min:	0	Max:	0	Mean:	0.00	Std Dev:	0.00
4.	Weight (no shoes) — with Age & Sex breakdowns												
	Total Population:	N valid:	94	N missing:	0	Min:	102	Max:	245	Mean:	153.06	Std Dev:	30.87
	BY SEX: MALE:	N valid:	43	N missing:	0	Min:	115	Max:	245	Mean:	176.23	Std Dev:	28.24
	BY SEX: FEMALE:	N valid:	51	N missing:	0	Min:	102	Max:	165	Mean:	133.53	Std Dev:	15.80
	BY AGE: 18 - 25 yrs:	N valid:	89	N missing:	0	Min:	102	Max:	245	Mean:	152.75	Std Dev:	31.46
	BY AGE: 25 - 34 yrs:	N valid:	5	N missing:	0	Min:	137	Max:	175	Mean:	158.60	Std Dev:	16.18
	BY AGE: 35 - 44 yrs:	N valid:	0	N missing:	0	Min:	0	Max:	0	Mean:	0.00	Std Dev:	0.00
	BY AGE: 45 - 54 yrs:	N valid:	0	N missing:	0	Min:	0	Max:	0	Mean:	0.00	Std Dev:	0.00
	BY AGE: 55 - 64 yrs:	N valid:	0	N missing:	0	Min:	0	Max:	0	Mean:	0.00	Std Dev:	0.00
	BY AGE: 65 + yrs:	N valid:	0	N missing:	0	Min:	0	Max:	0	Mean:	0.00	Std Dev:	0.00
5.	Body frame size	N valid:	81	N missing:	13	Cat #	1			SMALL n =	19	23.46% of valid resp.	
						Cat #	2			MEDIUM n =	49	60.49% of valid resp.	
						Cat #	3			LARGE n =	13	16.05% of valid resp.	
COMP	Body mass index	N valid:	94	N missing:	0	Min:	17	Max:	34	Mean:	22.86	Std Dev:	2.83

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COMP	Obesity	N valid: 94	N missing: 0	Cat # 1	NORMAL n =	64	68.09% of valid resp.
				Cat # 2	10%OVER n =	18	19.15% of valid resp.
				Cat # 3	20%OVER n =	12	12.77% of valid resp.
6.	Ever had diabetes	N valid: 89	N missing: 5	Cat # 1	YES n =	0	0.00% of valid resp.
				Cat # 2	NO n =	89	100.00% of valid resp.
7.	Blood pressure meds.	N valid: 94	N missing: 0	Cat # 1	YES n =	1	1.06% of valid resp.
				Cat # 2	NO n =	93	98.94% of valid resp.

8. Systolic BP — with Age & Sex breakdowns

	N valid:	N missing:	Min:	Max:	Mean:	Std Dev:
Total Population:	22	72	87	139	117.95	11.02
BY SEX: MALE:	8	35	110	139	122.13	9.28
BY SEX: FEMALE:	14	37	87	137	115.57	11.22
BY AGE: 18 - 25 yrs:	21	68	87	139	117.67	11.20
BY AGE: 25 - 34 yrs:	1	4	124	124	124.00	0.00
BY AGE: 35 - 44 yrs:	0	0	0	0	0.00	0.00
BY AGE: 45 - 54 yrs:	0	0	0	0	0.00	0.00
BY AGE: 55 - 64 yrs:	0	0	0	0	0.00	0.00
BY AGE: 65 + yrs:	0	0	0	0	0.00	0.00

Diastolic BP — with Age & Sex breakdowns

	N valid:	N missing:	Min:	Max:	Mean:	Std Dev:
Total Population:	22	72	52	89	74.14	9.09
BY SEX: MALE:	8	35	60	89	78.38	7.61
BY SEX: FEMALE:	14	37	52	80	71.71	8.97
BY AGE: 18 - 25 yrs:	21	68	52	89	74.00	9.28
BY AGE: 25 - 34 yrs:	1	4	77	77	77.00	0.00
BY AGE: 35 - 44 yrs:	0	0	0	0	0.00	0.00
BY AGE: 45 - 54 yrs:	0	0	0	0	0.00	0.00
BY AGE: 55 - 64 yrs:	0	0	0	0	0.00	0.00
BY AGE: 65 + yrs:	0	0	0	0	0.00	0.00

COMP	Blood Pressure	N valid: 94	N missing: 0	Cat # 1	OK (UNDER 140/90) n =	93	98.94% of valid resp.
				Cat # 2	HIGH (140/90 & OVER) n =	1	1.06% of valid resp.
9.	Blood pressure range	N valid: 72	N missing: 0	Cat # 1	HIGH n =	1	1.39% of valid resp.
				Cat # 2	LOW OR NORMAL n =	53	73.61% of valid resp.
				Cat # 3	DON'T KNOW n =	18	25.00% of valid resp.

10. Total cholesterol — with Age & Sex breakdowns

	N valid:	N missing:	Min:	Max:	Mean:	Std Dev:
Total Population:	9	85	0	220	139.33	77.80
BY SEX: MALE:	5	38	0	198	132.00	68.83
BY SEX: FEMALE:	4	47	0	220	148.50	86.86
BY AGE: 18 - 25 yrs:	8	81	0	220	156.75	63.87
BY AGE: 25 - 34 yrs:	1	4	0	0	0.00	0.00
BY AGE: 35 - 44 yrs:	0	0	0	0	0.00	0.00
BY AGE: 45 - 54 yrs:	0	0	0	0	0.00	0.00
BY AGE: 55 - 64 yrs:	0	0	0	0	0.00	0.00
BY AGE: 65 + yrs:	0	0	0	0	0.00	0.00

COMP	Cholesterol	N valid: 7	N missing: 87	Cat # 1	UNDER 200 n =	6	85.71% of valid resp.
				Cat # 2	200-239 n =	1	14.29% of valid resp.
				Cat # 3	240+ n =	0	0.00% of valid resp.
11.	HDL cholesterol	N valid: 0	N missing: 94	Min: 0	Max: 0	Mean: 0.00	Std Dev: 0.00
12.	Cigars per day	N valid: 93	N missing: 1	Cat # 1	NONE n =	89	95.70% of valid resp.
				Cat # 2	1 PER DAY n =	1	1.08% of valid resp.
				Cat # 3	2+ PER DAY n =	3	3.23% of valid resp.

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13.	Pipes per day	N valid: 93	N missing: 1	Cat # 1	NONE n =	93	100.00% of valid resp.
				Cat # 2	1 PER DAY n =	0	0.00% of valid resp.
				Cat # 3	2+ PER DAY n =	0	0.00% of valid resp.
14.	Smokeless tobacco	N valid: 92	N missing: 2	Cat # 1	NONE n =	90	97.83% of valid resp.
				Cat # 2	1 PER DAY n =	1	1.09% of valid resp.
				Cat # 3	2+ PER DAY n =	1	1.09% of valid resp.
COMP	Cigarette smoking	N valid: 94	N missing: 0	Cat # 1	NEVER n =	62	65.96% of valid resp.
				Cat # 2	EX-SMOKER n =	15	15.96% of valid resp.
				Cat # 3	CURRENT<20 n =	16	17.02% of valid resp.
				Cat # 4	HEAVY:20+ n =	1	1.06% of valid resp.

16. Cigarettes a day — with Age & Sex breakdowns

Total Population:	N valid: 17	N missing: 0	Response: 0 or none	n =	1		5.88% of total group
			: 1 or more	n =	16		94.12% of total group
	For responses of 1 or more:		Min: 1	Max: 20	Mean:	6.19	Std Dev:	4.82
BY SEX: MALE:	N valid: 10	N missing: 0	Response: 0 or none	n =	1		10.00% of total group
			: 1 or more	n =	9		90.00% of total group
	For responses of 1 or more:		Min: 1	Max: 20	Mean:	7.78	Std Dev:	5.29
BY SEX: FEMALE:	N valid: 7	N missing: 0	Response: 0 or none	n =	0		0.00% of total group
			: 1 or more	n =	7		100.00% of total group
	For responses of 1 or more:		Min: 1	Max: 10	Mean:	4.14	Std Dev:	3.14
BY AGE: 18 - 25 yrs:	N valid: 17	N missing: 0	Response: 0 or none	n =	1		5.88% of total group
			: 1 or more	n =	16		94.12% of total group
	For responses of 1 or more:		Min: 1	Max: 20	Mean:	6.19	Std Dev:	4.82
BY AGE: 25 - 34 yrs:	N valid: 0	N missing: 0	Response: 0 or none	n =	0		00% of total group
			: 1 or more	n =	0		00% of total group
	For responses of 1 or more:		Min: .0	Max: 0	Mean:	0.00	Std Dev:	0.00
BY AGE: 35 - 44 yrs:	N valid: 0	N missing: 0	Response: 0 or none	n =	0		00% of total group
			: 1 or more	n =	0		00% of total group
	For responses of 1 or more:		Min: 0	Max: 0	Mean:	0.00	Std Dev:	0.00
BY AGE: 45 - 54 yrs:	N valid: 0	N missing: 0	Response: 0 or none	n =	0		00% of total group
			: 1 or more	n =	0		00% of total group
	For responses of 1 or more:		Min: 0	Max: 0	Mean:	0.00	Std Dev:	0.00
BY AGE: 55 - 64 yrs:	N valid: 0	N missing: 0	Response: 0 or none	n =	0		00% of total group
			: 1 or more	n =	0		00% of total group
	For responses of 1 or more:		Min: 0	Max: 0	Mean:	0.00	Std Dev:	0.00
BY AGE: 65 + yrs:	N valid: 0	N missing: 0	Response: 0 or none	n =	0		00% of total group
			: 1 or more	n =	0		00% of total group
	For responses of 1 or more:		Min: 0	Max: 0	Mean:	0.00	Std Dev:	0.00
17a	Years since you quit	N valid: 15	N missing: 0	Response: 0 or none	n =	1		6.67% of total group
				: 1 or more	n =	14		93.33% of total group
	For responses of 1 or more:		Min: 1	Max: 9	Mean:	2.36	Std Dev:	2.19
17b	Cigarettes pre-quit	N valid: 15	N missing: 0	Response: 0 or none	n =	0		0.00% of total group
				: 1 or more	n =	15		100.00% of total group
	For responses of 1 or more:		Min: 1	Max: 20	Mean:	8.40	Std Dev:	4.73
18a	Miles by car	N valid: 93	N missing: 1	Min: 0	Max: 50	Mean:	13.27	Std Dev:	8.93
18b	Miles by motorcycle	N valid: 94	N missing: 0	Min: 0	Max: 5	Mean:	0.06	Std Dev:	0.52

Group Summary Report

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19.	Typical travel	N valid: 86	N missing: 8	Cat # 1	WALK n =	16	18.60% of valid resp.
				Cat # 2	BICYCLE n =	1	1.16% of valid resp.
				Cat # 3	MOTORCYCLE n =	0	0.00% of valid resp.
				Cat # 4	COMPACT CAR n =	29	33.72% of valid resp.
				Cat # 5	MID/FULL SIZE CAR n =	25	29.07% of valid resp.
				Cat # 6	TRUCK OR VAN n =	14	16.28% of valid resp.
				Cat # 7	BUS OR TRAIN n =	1	1.16% of valid resp.
				Cat # 8	MOSTLY STAY HOME n =	0	0.00% of valid resp.
20.	Seatbelt percent	N valid: 92	N missing: 1	Cat # 1	NEVER (0%) n =	3	3.26% of valid resp.
				Cat # 2	SELDOM (1-39%) n =	7	7.61% of valid resp.
				Cat # 3	SOMETIMES (40-79%) n =	15	16.30% of valid resp.
				Cat # 4	USUALLY (80-99%) n =	20	21.74% of valid resp.
				Cat # 5	ALWAYS (100%) n =	47	51.09% of valid resp.
21.	Average driving speed	N valid: 93	N missing: 0	Cat # 1	< 5 MPH OVER LIMIT n =	16	17.20% of valid resp.
				Cat # 2	6-10 MPH OVER LIMIT n =	56	60.22% of valid resp.
				Cat # 3	11-15 MPH OVER LIMIT n =	17	18.28% of valid resp.
				Cat # 4	15+ MPH OVER LIMIT n =	4	4.30% of valid resp.
22.	Drive after drinking	N valid: 90	N missing: 3	Response: 0 or none	n = 45		48.39% of total group
				: 1 or more	n = 48		51.61% of total group
		For responses of 1 or more:		Min: 1	Max: 40	Mean: 4.44	Std Dev: 6.24
23.	Alcohol per week	N valid: 93	N missing: 1	Response: 0 or none	n = 19		20.21% of total group
				: 1 or more	n = 75		79.79% of total group
		For responses of 1 or more:		Min: 1	Max: 50	Mean: 9.99	Std Dev: 9.81

23. Alcohol per week — with Age & Sex breakdowns

Total Population:	N valid: 93	N missing: 1	Min: 0	Max: 50	Mean: 8.05	Std Dev: 9.65
BY SEX: MALE:	N valid: 43	N missing: 0	Min: 0	Max: 50	Mean: 12.23	Std Dev: 12.02
BY SEX: FEMALE:	N valid: 50	N missing: 1	Min: 0	Max: 20	Mean: 4.46	Std Dev: 4.61
BY AGE: 18 - 25 yrs:	N valid: 88	N missing: 1	Min: 0	Max: 50	Mean: 7.98	Std Dev: 9.57
BY AGE: 25 - 34 yrs:	N valid: 5	N missing: 0	Min: 0	Max: 30	Mean: 9.40	Std Dev: 10.98
BY AGE: 35 - 44 yrs:	N valid: 0	N missing: 0	Min: 0	Max: 0	Mean: 0.00	Std Dev: 0.00
BY AGE: 45 - 54 yrs:	N valid: 0	N missing: 0	Min: 0	Max: 0	Mean: 0.00	Std Dev: 0.00
BY AGE: 55 - 64 yrs:	N valid: 0	N missing: 0	Min: 0	Max: 0	Mean: 0.00	Std Dev: 0.00
BY AGE: 65 + yrs:	N valid: 0	N missing: 0	Min: 0	Max: 0	Mean: 0.00	Std Dev: 0.00

24.	Age at first period	N valid: 50	N missing: 1	Cat # 1	11 OR UNDER n =	12	24.00% of valid resp.
				Cat # 2	12-13 YEARS OLD n =	28	56.00% of valid resp.
				Cat # 3	14 OR OVER n =	10	20.00% of valid resp.
25.	Age at first birth	N valid: 51	N missing: 0	Cat # 1	NO CHILDREN n =	50	98.04% of valid resp.
				Cat # 2	UNDER 20 n =	0	0.00% of valid resp.
				Cat # 3	20-24 n =	1	1.96% of valid resp.
				Cat # 4	25-29 n =	0	0.00% of valid resp.
				Cat # 5	30 OR OVER n =	0	0.00% of valid resp.
26.	Years since Mammogram	N valid: 51	N missing: 0	Cat # 1	WITHIN 1 YEAR n =	8	15.69% of valid resp.
				Cat # 2	1 YEAR AGO n =	2	3.92% of valid resp.
				Cat # 3	2 YEARS AGO n =	0	0.00% of valid resp.
				Cat # 4	3 OR MORE YEARS AGO n =	0	0.00% of valid resp.
				Cat # 5	NEVER n =	41	80.39% of valid resp.
27.	Family breast cancer	N valid: 51	N missing: 0	Cat # 1	NONE n =	41	80.39% of valid resp.
				Cat # 2	ONE n =	4	7.84% of valid resp.
				Cat # 3	2 OR MORE n =	2	3.92% of valid resp.
				Cat # 4	DON'T KNOW n =	4	7.84% of valid resp.

Group Summary Report

February 6, 2000 Questionnaire: PRA

28.	Hysterectomy	N valid:	49	N missing:	2	Cat #	1	YES n =	0	0.00% of valid resp.
						Cat #	2	NO n =	49	100.00% of valid resp.
29.	Years since pap smear	N valid:	51	N missing:	0	Cat #	1	WITHIN 1 YEAR n =	31	60.78% of valid resp.
						Cat #	2	1 YEAR AGO n =	7	13.73% of valid resp.
						Cat #	3	2 YEARS AGO n =	0	0.00% of valid resp.
						Cat #	4	3 OR MORE YEARS AGO n =	2	3.92% of valid resp.
						Cat #	5	NEVER n =	11	21.57% of valid resp.
30.	Breast self exam	N valid:	50	N missing:	1	Cat #	1	MONTHLY n =	7	14.00% of valid resp.
						Cat #	2	EVERY FEW MONTHS n =	23	46.00% of valid resp.
						Cat #	3	RARELY OR NEVER n =	20	40.00% of valid resp.
31.	Breast MD exam	N valid:	51	N missing:	0	Cat #	1	WITHIN 1 YEAR n =	30	58.82% of valid resp.
						Cat #	2	1 YEAR AGO n =	10	19.61% of valid resp.
						Cat #	3	2 YEARS AGO n =	0	0.00% of valid resp.
						Cat #	4	3 OR MORE YEARS AGO n =	2	3.92% of valid resp.
						Cat #	5	NEVER n =	9	17.65% of valid resp.
32.	Women: rectal exam	N valid:	48	N missing:	3	Cat #	1	WITHIN 1 YEAR n =	6	12.50% of valid resp.
						Cat #	2	1 YEAR AGO n =	1	2.08% of valid resp.
						Cat #	3	2 YEARS AGO n =	0	0.00% of valid resp.
						Cat #	4	3 OR MORE YEARS AGO n =	1	2.08% of valid resp.
						Cat #	5	NEVER n =	40	83.33% of valid resp.
33.	Men: rect/prost exam	N valid:	42	N missing:	1	Cat #	1	WITHIN 1 YEAR n =	1	2.38% of valid resp.
						Cat #	2	1 YEAR AGO n =	3	7.14% of valid resp.
						Cat #	3	2 YEARS AGO n =	2	4.76% of valid resp.
						Cat #	4	3 OR MORE YEARS AGO n =	4	9.52% of valid resp.
						Cat #	5	NEVER n =	32	76.19% of valid resp.
34.	Witness violence	N valid:	92	N missing:	2	Cat #	1	4 OR MORE TIMES n =	5	5.43% of valid resp.
						Cat #	2	2-3 TIMES n =	10	10.87% of valid resp.
						Cat #	3	ONCE OR NEVER n =	65	70.65% of valid resp.
						Cat #	4	NOT SURE n =	12	13.04% of valid resp.
35.	Overall health	N valid:	94	N missing:	0	Cat #	1	EXCELLENT n =	24	25.53% of valid resp.
						Cat #	2	GOOD n =	58	61.70% of valid resp.
						Cat #	3	FAIR n =	11	11.70% of valid resp.
						Cat #	4	POOR n =	1	1.06% of valid resp.
36.	Exercise/week	N valid:	83	N missing:	11	Cat #	1	LESS THAN ONCE/WEEK n =	5	6.02% of valid resp.
						Cat #	2	1 OR 2 TIMES A WEEK n =	29	34.94% of valid resp.
						Cat #	3	3+ TIMES A WEEK n =	49	59.04% of valid resp.
37.	Motorcycle helmet use	N valid:	1	N missing:	1	Cat #	1	75-100% OF THE TIME n =	1	100.00% of valid resp.
						Cat #	2	25-74% OF THE TIME n =	0	0.00% of valid resp.
						Cat #	3	<25% OF THE TIME n =	0	0.00% of valid resp.
						Cat #	4	DOESN'T APPLY TO ME n =	0	0.00% of valid resp.
38.	High FIBER food daily	N valid:	89	N missing:	5	Cat #	1	YES n =	74	83.15% of valid resp.
						Cat #	2	NO n =	15	16.85% of valid resp.
39.	High FAT food daily	N valid:	86	N missing:	8	Cat #	1	YES n =	62	72.09% of valid resp.
						Cat #	2	NO n =	24	27.91% of valid resp.
40.	Life satisfaction	N valid:	77	N missing:	17	Cat #	1	MOSTLY SATISFIED n =	60	77.92% of valid resp.
						Cat #	2	PARTLY SATISFIED n =	14	18.18% of valid resp.
						Cat #	3	NOT SATISFIED n =	3	3.90% of valid resp.

Group Summary Report

February 6, 2000 Questionnaire: PRA

41.	Personal losses	N valid:	94	N missing:	0	Cat #	1	ONE n =	26	27.66% of valid resp.
						Cat #	2	TWO OR MORE n =	9	9.57% of valid resp.
						Cat #	3	NONE n =	59	62.77% of valid resp.
42a	Racial group	N valid:	92	N missing:	2	Cat #	1	AMERICAN INDIAN n =	0	0.00% of valid resp.
						Cat #	2	ASIAN n =	3	3.26% of valid resp.
						Cat #	3	BLACK n =	3	3.26% of valid resp.
						Cat #	4	PACIFIC ISLANDER n =	1	1.09% of valid resp.
						Cat #	5	WHITE n =	75	81.52% of valid resp.
						Cat #	6	OTHER n =	10	10.87% of valid resp.
						Cat #	7	DON'T KNOW n =	0	0.00% of valid resp.
42b	Hispanic origin	N valid:	91	N missing:	3	Cat #	1	YES n =	9	9.89% of valid resp.
						Cat #	2	NO n =	82	90.11% of valid resp.
43.	Highest grade	N valid:	93	N missing:	1	Cat #	1	GRADE SCHOOL n =	0	0.00% of valid resp.
						Cat #	2	SOME HIGH SCHOOL n =	0	0.00% of valid resp.
						Cat #	3	HIGH SCHOOL GRADUATE n =	5	5.38% of valid resp.
						Cat #	4	SOME COLLEGE n =	82	88.17% of valid resp.
						Cat #	5	COLLEGE GRADUATE n =	6	6.45% of valid resp.
						Cat #	6	POST-GRADUATE n =	0	0.00% of valid resp.
44.	Occupation	N valid:	89	N missing:	5	Cat #	1	HEALTH n =	2	2.25% of valid resp.
						Cat #	2	MANAGER/EDUC./PROF. n =	2	2.25% of valid resp.
						Cat #	3	TECHNICAL/SALES n =	1	1.12% of valid resp.
						Cat #	4	LABORER n =	1	1.12% of valid resp.
						Cat #	5	STUDENT n =	78	87.64% of valid resp.
						Cat #	6	RETIRED n =	0	0.00% of valid resp.
						Cat #	7	HOMEMAKER n =	1	1.12% of valid resp.
						Cat #	8	SERVICE n =	3	3.37% of valid resp.
						Cat #	9	SKILLED CRAFTS n =	0	0.00% of valid resp.
						Cat #	10	UNEMPLOYED n =	0	0.00% of valid resp.
						Cat #	11	OTHER n =	1	1.12% of valid resp.
45.	Industry	N valid:	85	N missing:	9	Cat #	1	UTILITIES n =	0	0.00% of valid resp.
						Cat #	2	TRANSPORT n =	2	2.35% of valid resp.
						Cat #	3	FARM/FISH/FORESTRY n =	3	3.53% of valid resp.
						Cat #	4	SALES n =	12	14.12% of valid resp.
						Cat #	5	FINANCIAL n =	7	8.24% of valid resp.
						Cat #	6	MINING n =	0	0.00% of valid resp.
						Cat #	7	GOVERNMENT n =	5	5.88% of valid resp.
						Cat #	8	MANUFACTURE n =	0	0.00% of valid resp.
						Cat #	9	CONSTRUCTION n =	2	2.35% of valid resp.
						Cat #	10	OTHER n =	54	63.53% of valid resp.
46.	Optional question	N valid:	0	N missing:	0	Cat #	1	ONE n =	0	0.00% of valid resp.
						Cat #	2	TWO n =	0	0.00% of valid resp.
						Cat #	3	THREE n =	0	0.00% of valid resp.
						Cat #	4	FOUR n =	0	0.00% of valid resp.
						Cat #	5	FIVE n =	0	0.00% of valid resp.
						Cat #	6	SIX n =	0	0.00% of valid resp.
						Cat #	7	SEVEN n =	0	0.00% of valid resp.
						Cat #	8	EIGHT n =	0	0.00% of valid resp.
						Cat #	9	NINE n =	0	0.00% of valid resp.

Group Summary Report

February 6, 2000 Questionnaire: PRA

47.	Optional question	N valid:	0	N missing:	0	Cat #	1	ONE n =	0	0.00% of valid resp.
						Cat #	2	TWO n =	0	0.00% of valid resp.
						Cat #	3	THREE n =	0	0.00% of valid resp.
						Cat #	4	FOUR n =	0	0.00% of valid resp.
						Cat #	5	FIVE n =	0	0.00% of valid resp.
						Cat #	6	SIX n =	0	0.00% of valid resp.
						Cat #	7	SEVEN n =	0	0.00% of valid resp.
						Cat #	8	EIGHT n =	0	0.00% of valid resp.
						Cat #	9	NINE n =	0	0.00% of valid resp.

APPENDIX E

PERSONAL RISK ANALYSIS GROUP SUMMARY

PERSONAL RISK ANALYSIS GROUP SUMMARY
SEVENTH-DAY ADVENTIST

This report summarizes health and safety practices in your group. It identifies costly risk areas for the group as a whole, compares the group to national averages, makes ten-year health outcome projections, and identifies risk reduction opportunities.

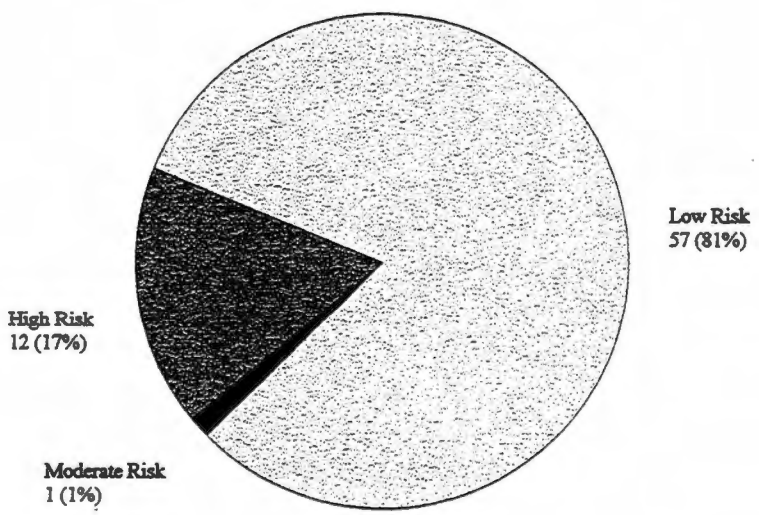
People who are "Low Risk" in the chart below have the best chances for living long and healthy lives. People in the Low Risk category score in the top 25% of people who have taken the PRA questionnaire.

"Moderate Risk" refers to U.S. averages – not ideals. On the average, too many Americans smoke, don't get enough exercise, eat too much fat, and are overweight. People in the Moderate Risk category could benefit from health promotion programs that move them to lower risk.

"High Risk" people are at significant risk for early death from disease or accidents. People with high controllable risk factors also cost unnecessary billions of dollars annually in direct health care costs, absenteeism, and accidents. People in the High Risk category score in the lowest 25% of people who have taken the PRA questionnaire.

Risk reduction programs save lives and money.

Health Risk Status of This Group



Cases reported: 70
Missing data: 22

Demographics

The chart below breaks your group down by age and sex subgroups. There are 92 people in your group; 70 are included in this report.

Although older people face increasingly higher risks of death and disease, young people are also affected by smoking, diet, and safety practices.

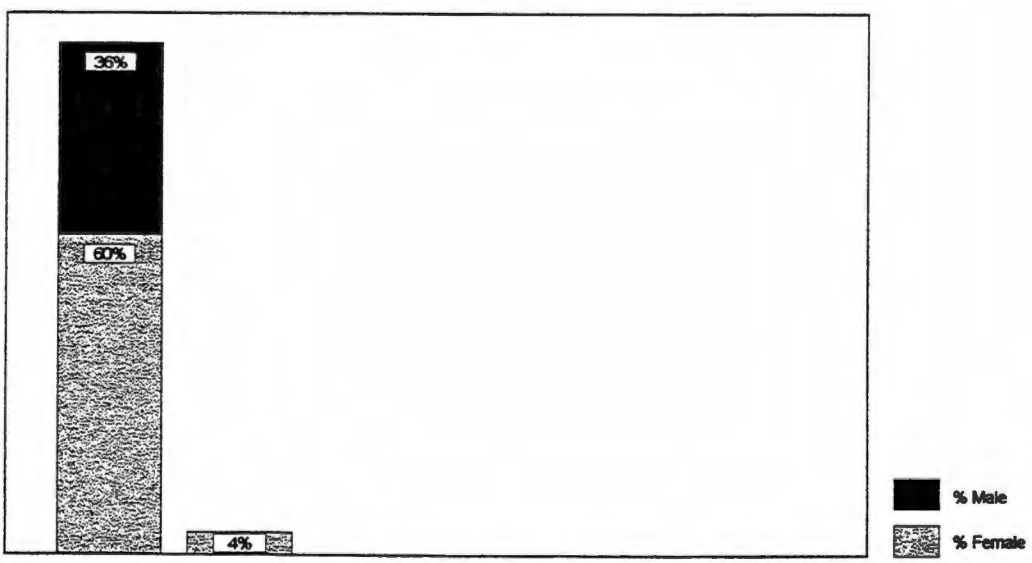
Habits become ingrained during the younger years -- long term physical damage accumulates as well. Although young people have relatively less to fear from major killers such as heart disease and cancer in the short run, they can substantially reduce their lifetime risks by modifying risky habits as soon as possible.

This report contains some sections addressing women's health alone, such as Pap smears and breast examination. The rest of the report is equally applicable to men and women.

It is a common idea that heart disease is primarily a men's disease. This is not so. Until menopause, women have some protection against heart disease. After that time, women are as susceptible to heart attack as men. Heart disease kills more women than any other disease -- twice as many as cancer, for instance.

Health promotion programs make sense -- for people of both sexes and all ages.

Age Groups by Sex



	Under 25 years	25-35 years	35-44 years	45-54 years	55-64 years	65 years and over	
COUNT:	67	3					25 males 45 females 70 total

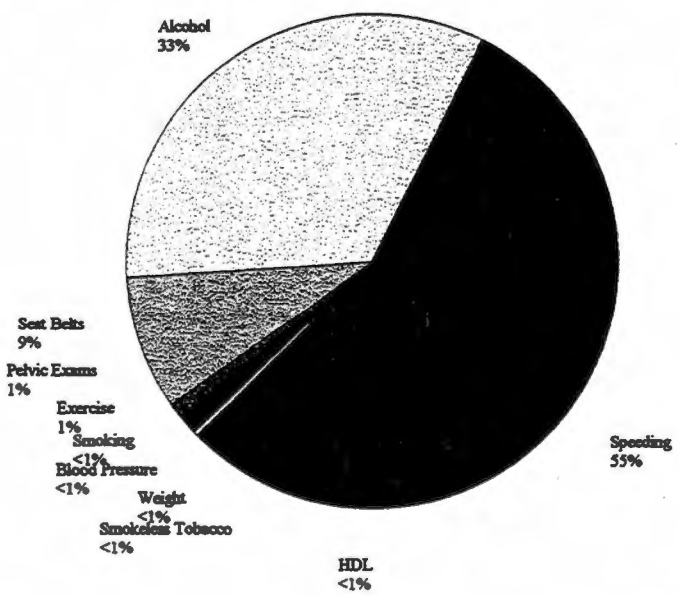
Risk Factors in this Group

Risk factors are conditions that shape the odds for early death and disability. They include habits, such as smoking and lack of exercise, and clinical measures, such as blood pressure and cholesterol.

Nearly half of the 2.15 million deaths in the U.S. in 1990 could have been prevented through behavioral changes.

The chart below shows how each of the risk factors measured by the questionnaire contributes to preventable deaths in your group. These estimates use an algorithm which compares respondents' risk profiles with a national data base of people with similar risk profiles. By looking at the outcomes of similar people, with similar habits, the algorithm projects this group's preventable deaths over the next ten years.

Risk Factors That Contribute to Preventable Deaths in Your Group



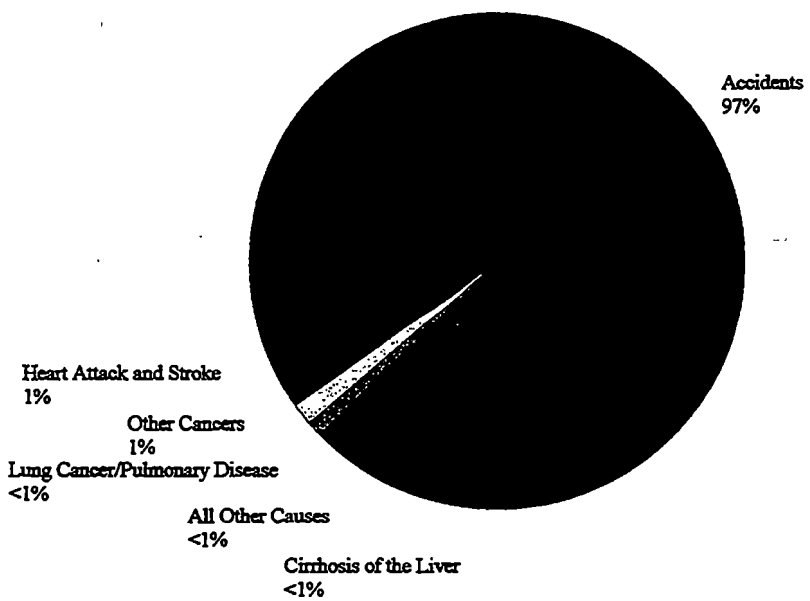
Preventable Causes of Death in this Group

The chart below predicts the relative rank of several major causes of deaths in this group. Please note that the questionnaire and report do not address all areas of health risk, including AIDS risk factors, gun use, and suicidal impulses. These may also be significant causes of death and disability.

Predictions are made for only the next ten year period. This underestimates the total impact of risk factors for heart attack and cancer for young people, because damage can accumulate for years and only result in disease after 20 or 30 years -- not only the ten years reflected in this projection.

Healthy behavior changes made now will reap an even bigger benefit in the years to come.

Preventable Deaths by Disease Category



U.S. Average now:

29% are smokers.

Healthy People 2000 goals:

No more than 15% smokers among adults over 20.

Ideal:

No one smokes.

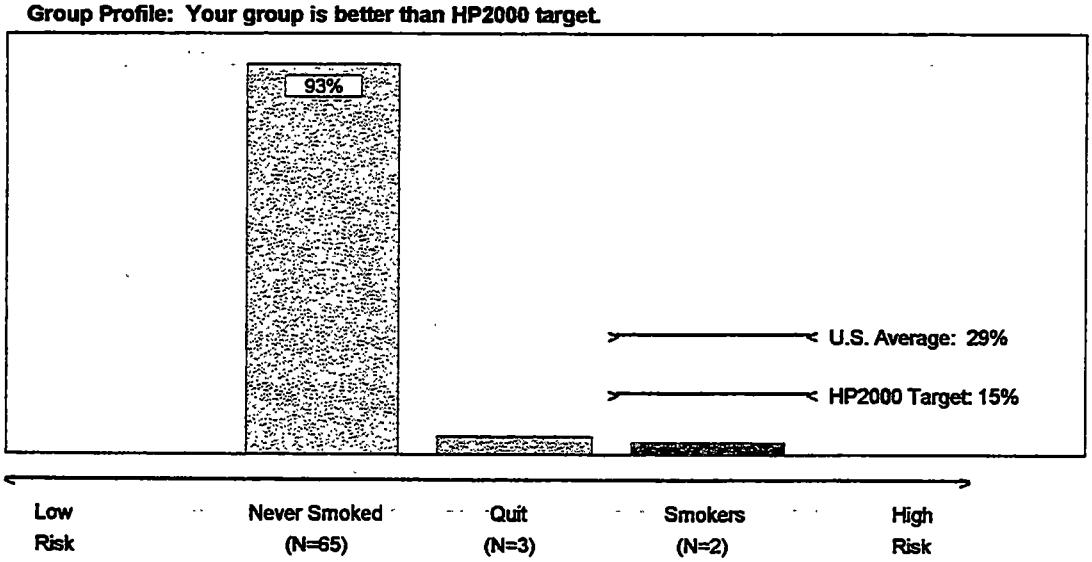
Cigarette Smoking

A 1993 analysis implicates smoking in 19% of all deaths in the U.S. each year. These include deaths from cancer, heart disease, stroke, pulmonary disease, low birth weight and other causes.

Smoking is on the downswing, but quitting remains a difficult challenge for current smokers and young people are still taking up the habit in alarming numbers.

Smoking prevention and cessation would make the single largest impact on death and disease compared with any other risk reduction effort.

Group Profile: Your group is better than HP2000 target.



Risk Reduction Objectives

- Smoking cessation in current smokers
- Prevention of relapse in smokers who have quit
- Smoking prevention in children and young people
- Protection of non-smokers from second hand smoke.

Related Data

In this group, 1 (1.5%) use smokeless tobacco.
0 (0%) smoke a pipe or cigars.

Among smokers, (0%) smoke more than 20 cigarettes a day.

U.S. Average now:
26% are 20% or more over their ideal weight.

Healthy People 2000 goal:
No more than 20% be 20% or more overweight.

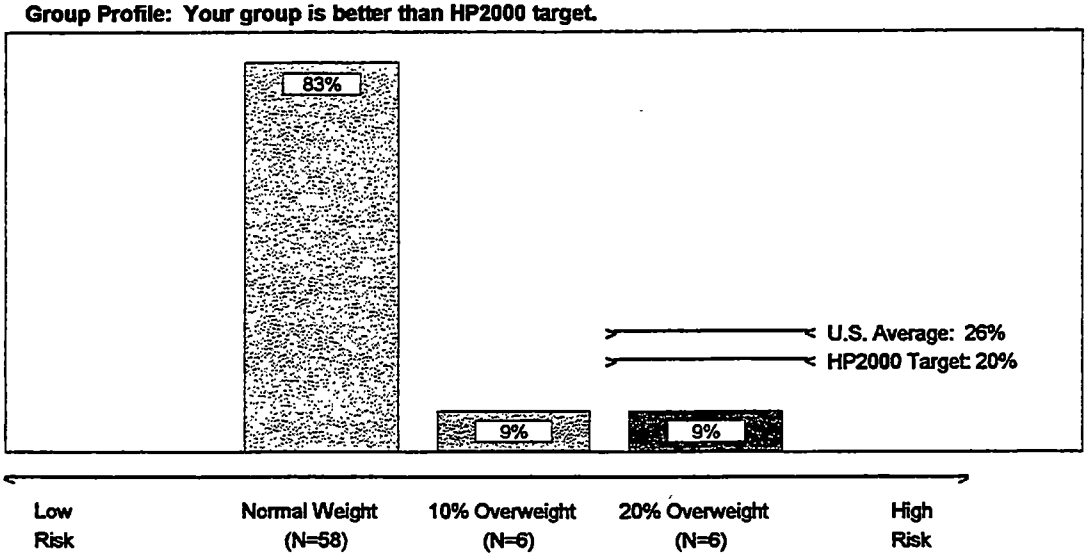
Ideal:
Everyone within 20% of ideal weight.

Overweight

Overweight is defined as a percentage over ideal weight, using the Metropolitan Relative Weight Tables. Ideal weights are adjusted for sex, height and frame size.

Although severe overweight can be a significant health risk factor, moderate heaviness is not as important as many people think. Other factors, such as general fitness and the distribution of weight on the body may make a bigger difference than actual weight. Concerns about potential weight gain should not stand in the way of making more important health changes, such as smoking cessation.

Group Profile: Your group is better than HP2000 target.



Risk Reduction Objectives

- Exercise
- Reduction of dietary fat
- Increase in dietary fiber
- Behavioral change in food consumption patterns

Related Data

In this group, 46 (68%) reported eating high-fat foods daily or more; 4 (6%) reported seldom eating foods high in fiber.

Group Risk Summary

U.S. Average now:
22% get moderate or light,
12% get vigorous exercise.

Healthy People 2000 goal:
50% get light, moderate, or vigorous exercise 3 or more times a week.

Ideal:
Everyone exercises.

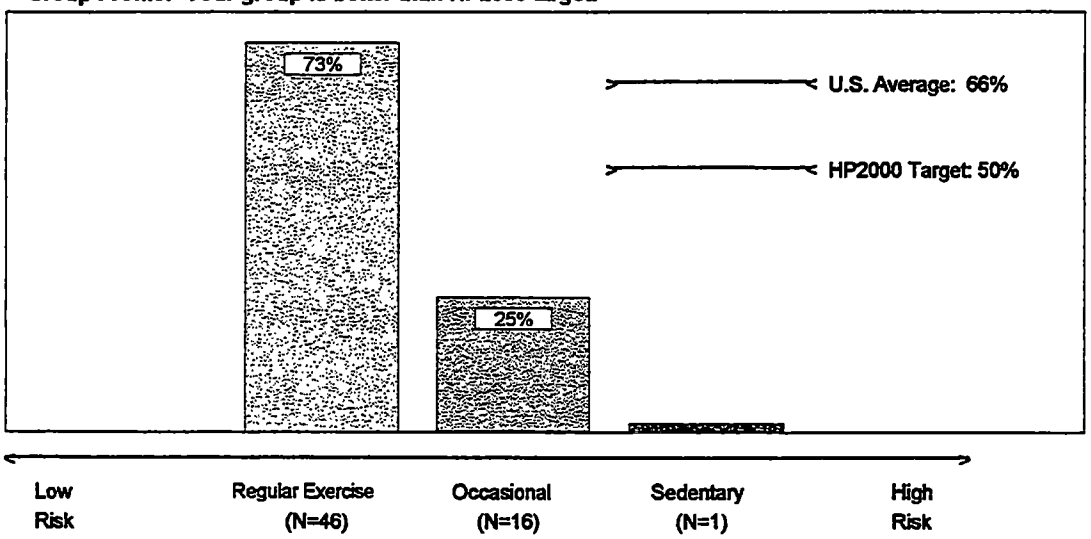
Exercise

A 1993 national study named the lack of exercise as a major behavioral cause of killing diseases – second only to cigarette smoking.

Fitness, stamina, and disease protection can be achieved with less exercise – and less vigorous exercise – than previously thought.

Moderate exercise 3-5 times a week, plus a general increase in daily activity levels can achieve aerobic fitness and improve alertness, weight control, and sound sleep. It can also help prevent heart disease and improve many chronic health problems.

Group Profile: Your group is better than HP2000 target.



Risk Reduction Objectives

- Walking
- Swimming
- Moderately active sports
- Dancing or aerobics class
- Fitness center
- Gardening or other activities
- General increase in daily activity level

Related Data

29 (41%) people in this group walk or ride a bicycle as their primary mode of transportation.

Blood Pressure

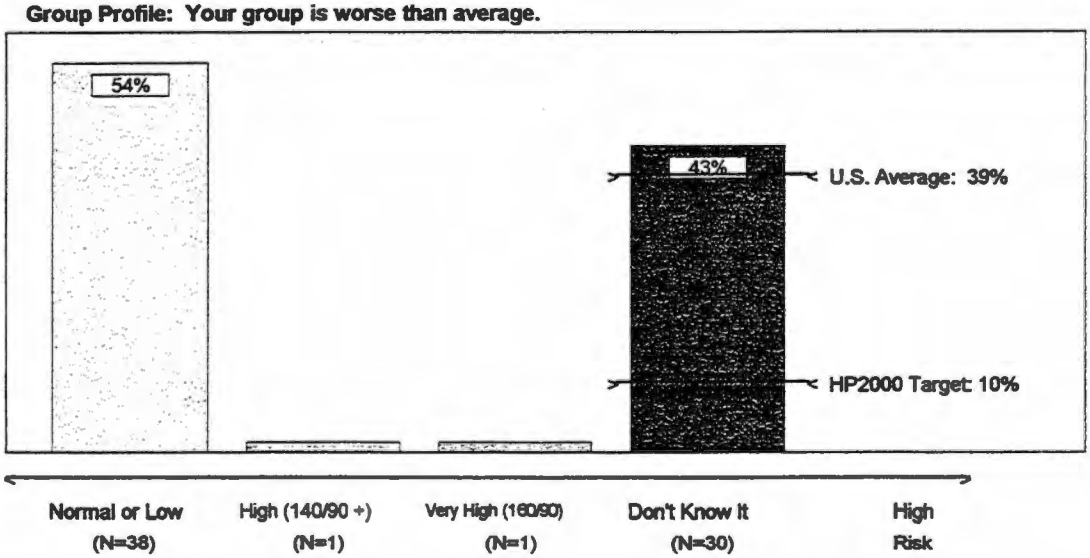
U.S. Average now:
61% know their BP; 35% are over 140/90.

Healthy People 2000 goal:
90% of adults screened and taking action if BP is high.

Ideal:
Everyone screened, those with high values taking action.

As many as 58 million Americans may have hypertension (blood pressure over 140/90). Many of these are unaware of the problem because hypertension by itself has no detectable physical symptoms.

Group Profile: Your group is worse than average.



Risk Reduction Objectives

- Screening for high blood pressure in the group as a whole.
- Prevention – through exercise, weight control, and a diet low in salt.
- Management of diagnosed hypertension through monitoring, diet, exercise, and possibly drugs.

Related Data

The average for this group is 110/69.

(0%) are taking medication to control high blood pressure.

(0%) have very high blood pressure but aren't taking medication for it.

Group Risk Summary

U.S. Average now:

27% are over 240, average is 213 for everyone.

Healthy People 2000 goal:

Under 20% over 240, average for everyone of 200.

Ideal:

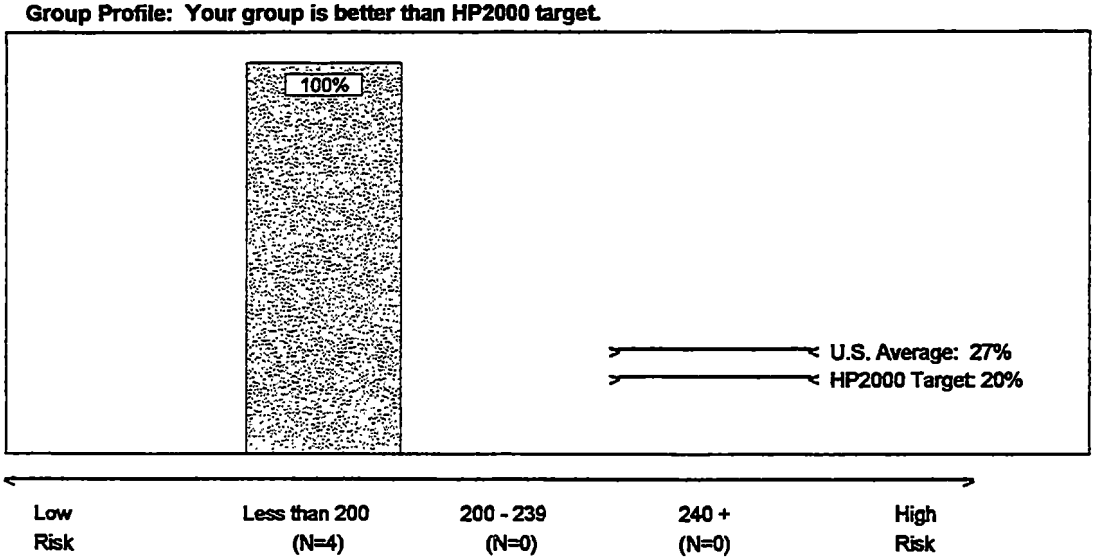
Everyone under 200.

Cholesterol

Blood lipids, including total serum cholesterol and HDL, play an important role in the development of cardiovascular disease.

Many people are confused about "good cholesterol" (HDL) and "bad cholesterol" (LDL) in the blood. There is also misunderstanding about dietary saturated fats, which include cholesterol from animal fats.

Group Profile: Your group is better than HP2000 target.



Risk Reduction Objectives

- Screening of the group as a whole for total serum cholesterol.
- HDL screening as recommended by physician.
- Education about fats in the diet and cholesterol in the bloodstream.
- Increased exercise.
- Reduced saturated fat in the diet.

Related Data

In this group, 2 (3%) knew their HDL. Of these, (0%) were in the high, protective range.

Average cholesterol is 78; average HDL is 47.

Group Risk Summary

U.S. Average now:

42% wear seatbelts regularly.

Healthy People 2000 goal:

85% wear seatbelts regularly.

Ideal:

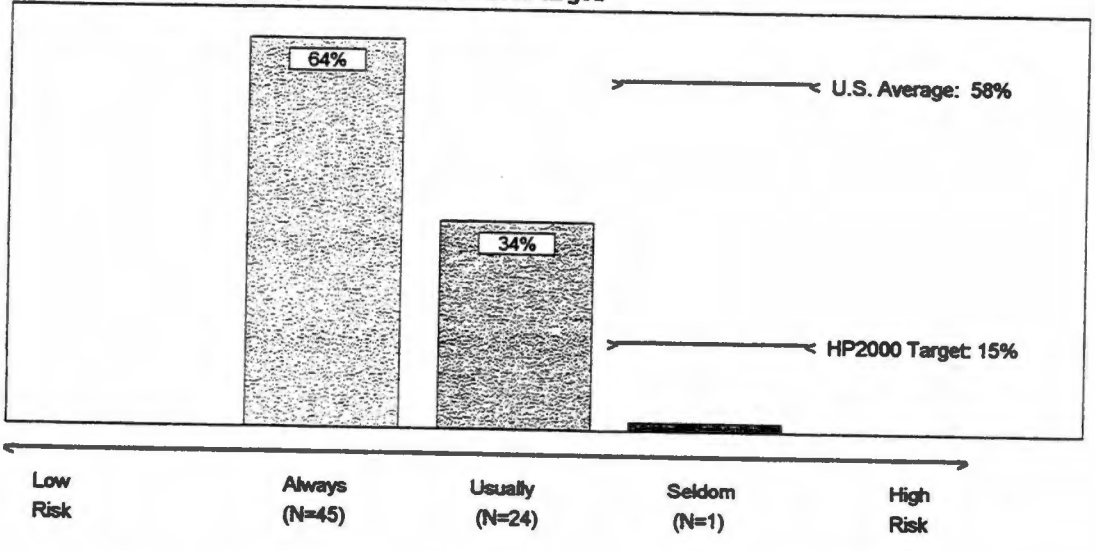
Everyone uses seatbelts regularly.

Seatbelts

The use of seatbelts has increased in recent years, and consistent use is highest where legal enforcement is the most strict.

Some people believe that airbags eliminate the need for seatbelts -- not true. Others think seatbelts aren't important in low speed local traffic. In most areas of the country, the majority of injury or fatal accidents occur on surface streets at relatively low speeds, not on high speed freeways.

Group Profile: Your group is better than HP2000 target.



Risk Reduction Objectives

- Consistent use of lap and shoulder seatbelts on all trips.
- Consistent and correct use of age-appropriate car seats and belts for infants and children.

Related Data

2 (3%) of this group reported often driving 15 MPH or more over the speed limit.

6 (9%) reported driving after drinking (or riding with a drinking driver) at least once in the past month.

Group Risk Summary

U.S. Average now:
8% drink 14+ per week.
13 drinks / week average.

Healthy People 2000 goal:
6% drink 14+ per week.
Under 10 drinks/week average.

Ideal:
No one averages more than 14 drinks per week.

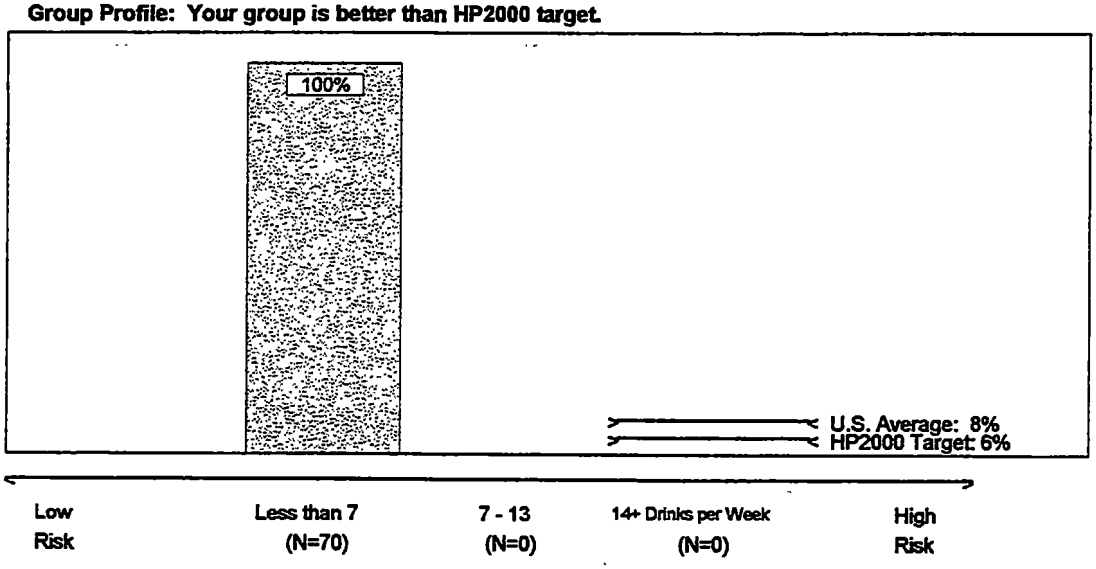
Alcohol

Alcohol is used by over half of all American adults, but it is difficult to estimate how many of these drinkers abuse alcohol.

Alcohol abuse can be drinking too much, drinking at inappropriate times, drinking to avoid issues and responsibilities, and being unable to take control of one's drinking habits.

Alcohol intoxication is involved in about half of all deaths from motor vehicle crashes, fires, drownings, homicides and suicides.

Group Profile: Your group is better than HP2000 target.



Risk Reduction Objectives

- No driving and drinking. Encourage designated drivers, alternative transportation, and moderation.
- No drinking during pregnancy.
- Light drinking among non-alcoholic drinkers.
- Abstinence among alcoholics.
- Delays in starting alcohol use among young people.

Related Data

The average for this group is 0 drinks per week.

6 (9%) reported driving after drinking (or riding with a drinking driver) at least once in the past month.

Group Risk Summary

U.S. Average now:
Less than 25% of women over 50 had a mammogram within the past 2 years.

HP2000 goal:
80% of women 50 and older get annual mammograms.

Ideal:
All at recommended intervals.

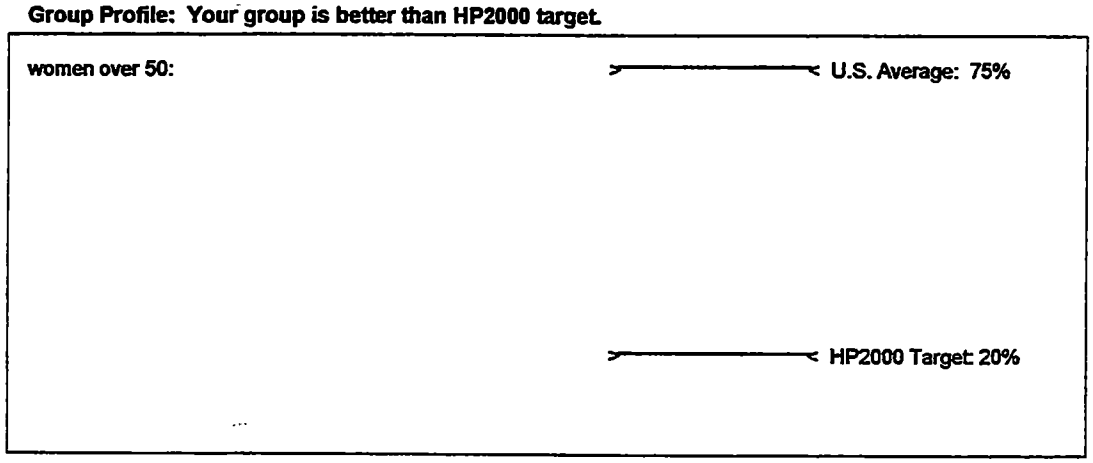
Mammogram

Some healthy practices may help prevent breast cancer from developing. These include a low fat diet and low alcohol consumption. At this point, the best known way to prevent breast cancer deaths rests with early detection.

Mammograms can and do reduce mortality by allowing earlier treatment with a greater chance of success.

Recommended frequency of screening varies with age and other risk factors such as a family history of breast cancer.

Group Profile: Your group is better than HP2000 target.



Risk Reduction Objectives

- First mammogram at physician's recommended age (this varies).
- Regular mammogram schedule thereafter (schedule varies with age and risk factors).

Related Data

The chart shows women age 50 and over. For women age 40-49, (0%) had a mammogram one year ago or less.

(20%) of all women in this group reported doing breast self exams monthly.

U.S. Average now:

56% had a Pap test in the previous year.

Healthy People 2000 goal:

75% of all women getting annual Pap tests.

Ideal:

All women at physician's recommended schedule.

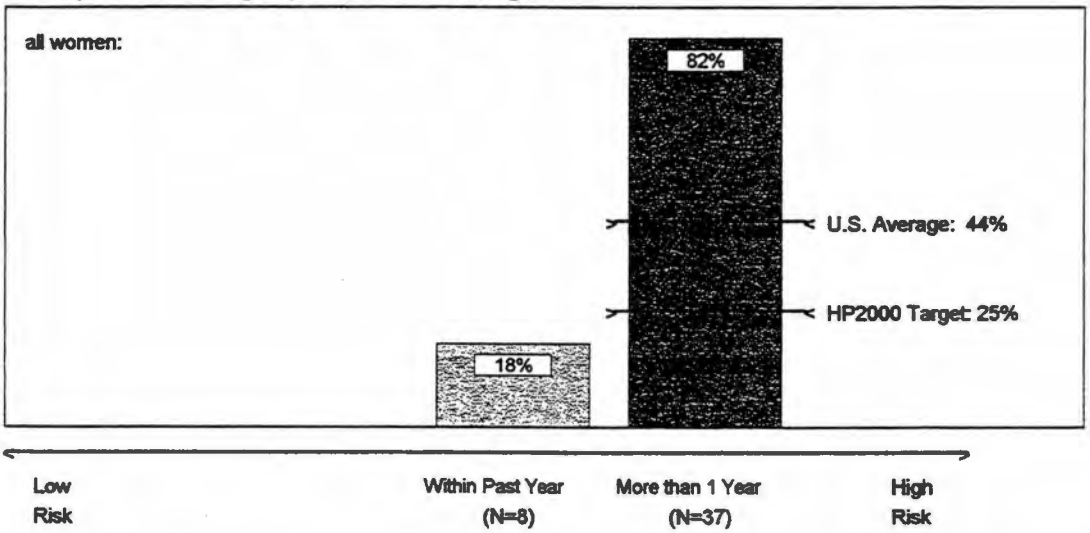
Pap Smear

Pap test screening for cervical cancer greatly reduces the risk of death from cervical cancer. The decline in cervical cancer mortality in the 1970's and 1980's is largely due to increased Pap screening.

A large number of women, especially older women at high risk, still don't have Pap tests at all, or less frequently than recommended.

Recommendations for frequency of screening vary; some advocate annual screening for all women, others claim that less often is sufficient.

Group Profile: Your group is worse than average.



Risk Reduction Objectives

- Regularly scheduled Pap tests -- annually or at physician's recommendation.

PERSONAL RISK ANALYSIS GROUP SUMMARY
STATE UNIVERSITY

This report summarizes health and safety practices in your group. It identifies costly risk areas for the group as a whole, compares the group to national averages, makes ten-year health outcome projections, and identifies risk reduction opportunities.

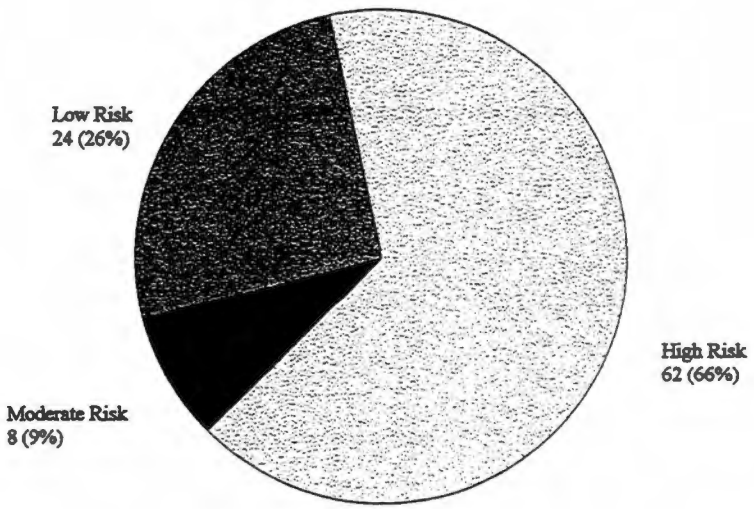
People who are "Low Risk" in the chart below have the best chances for living long and healthy lives. People in the Low Risk category score in the top 25% of people who have taken the PRA questionnaire.

"Moderate Risk" refers to U.S. averages -- not ideals. On the average, too many Americans smoke, don't get enough exercise, eat too much fat, and are overweight. People in the Moderate Risk category could benefit from health promotion programs that move them to lower risk.

"High Risk" people are at significant risk for early death from disease or accidents. People with high controllable risk factors also cost unnecessary billions of dollars annually in direct health care costs, absenteeism, and accidents. People in the High Risk category score in the lowest 25% of people who have taken the PRA questionnaire.

Risk reduction programs save lives and money.

Health Risk Status of This Group



Cases reported: 94
Missing data: 21

U.S. Average now:
22% get moderate or light,
12% get vigorous exercise.

Healthy People 2000 goal:
50% get light, moderate, or vigorous exercise 3 or more times a week.

Ideal:
Everyone exercises.

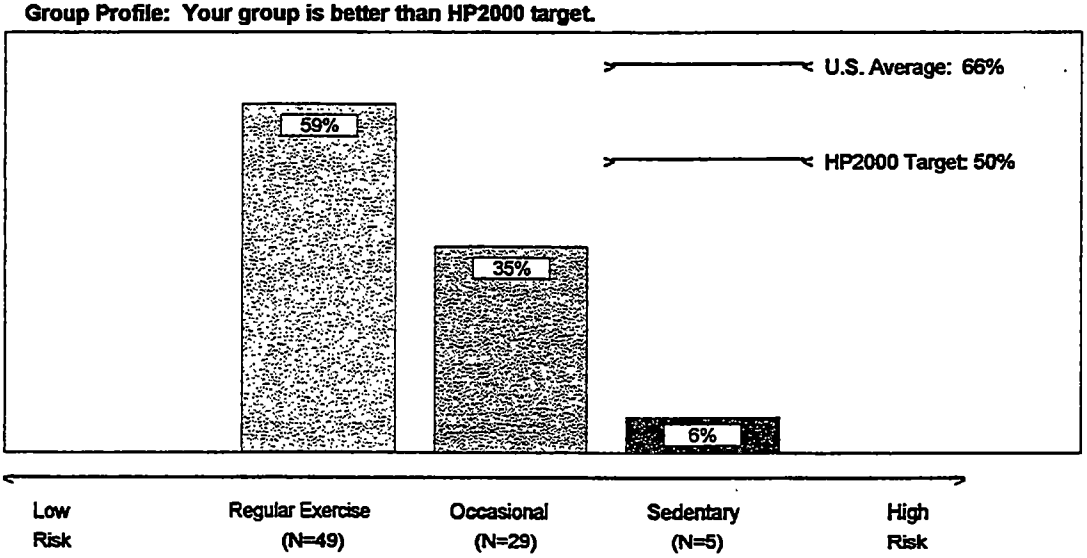
Exercise

A 1993 national study named the lack of exercise as a major behavioral cause of killing diseases – second only to cigarette smoking.

Fitness, stamina, and disease protection can be achieved with less exercise – and less vigorous exercise – than previously thought.

Moderate exercise 3-5 times a week, plus a general increase in daily activity levels can achieve aerobic fitness and improve alertness, weight control, and sound sleep. It can also help prevent heart disease and improve many chronic health problems.

Group Profile: Your group is better than HP2000 target.



Risk Reduction Objectives

- Walking
- Swimming
- Moderately active sports
- Dancing or aerobics class
- Fitness center
- Gardening or other activities
- General increase in daily activity level

Related Data

17 (18%) people in this group walk or ride a bicycle as their primary mode of transportation.

U.S. Average now:

29% are smokers.

Healthy People 2000 goals:

No more than 15% smokers among adults over 20.

Ideal:

No one smokes.

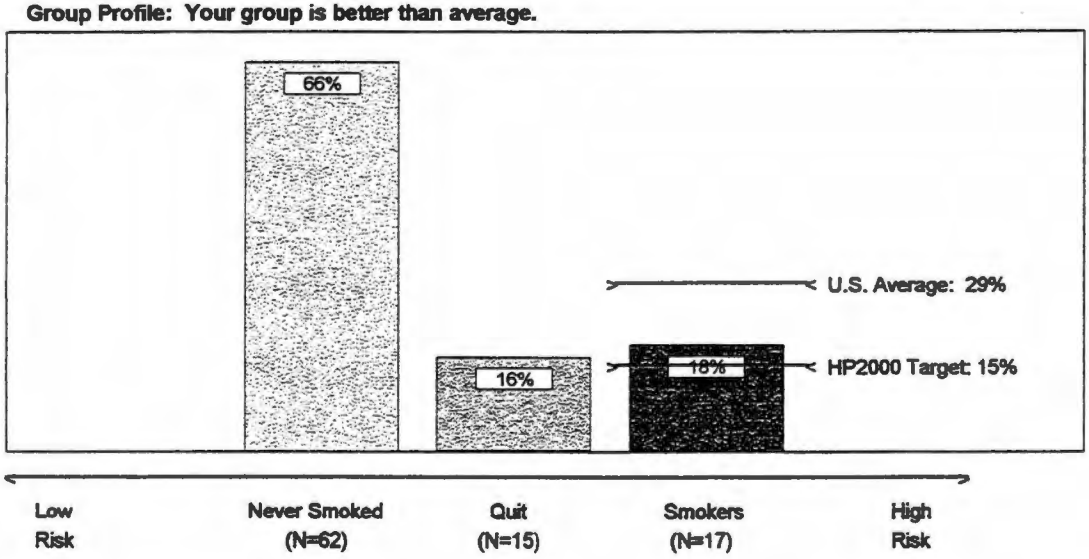
Cigarette Smoking

A 1993 analysis implicates smoking in 19% of all deaths in the U.S. each year. These include deaths from cancer, heart disease, stroke, pulmonary disease, low birth weight and other causes.

Smoking is on the downswing, but quitting remains a difficult challenge for current smokers and young people are still taking up the habit in alarming numbers.

Smoking prevention and cessation would make the single largest impact on death and disease compared with any other risk reduction effort.

Group Profile: Your group is better than average.



Risk Reduction Objectives

- Smoking cessation in current smokers
- Prevention of relapse in smokers who have quit
- Smoking prevention in children and young people
- Protection of non-smokers from second hand smoke.

Related Data

In this group, 2 (2%) use smokeless tobacco.
4 (4%) smoke a pipe or cigars.

Among smokers, 1 (1.1%) smoke more than 20 cigarettes a day.

Group Risk Summary

U.S. Average now:
26% are 20% or more over their ideal weight.

Healthy People 2000 goal:
No more than 20% be 20% or more overweight.

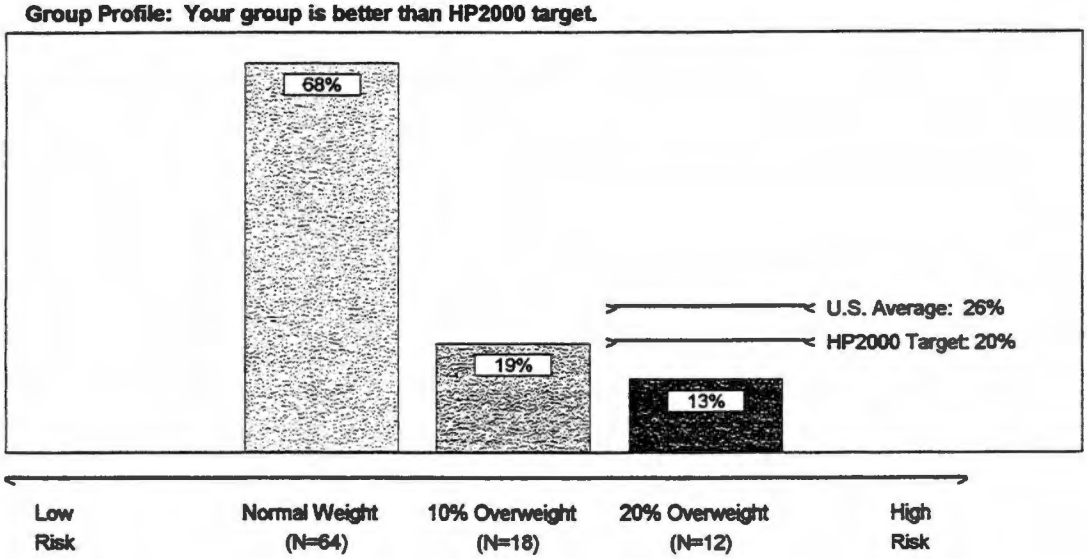
Ideal:
Everyone within 20% of ideal weight.

Overweight

Overweight is defined as a percentage over ideal weight, using the Metropolitan Relative Weight Tables. Ideal weights are adjusted for sex, height and frame size.

Although severe overweight can be a significant health risk factor, moderate heaviness is not as important as many people think. Other factors, such as general fitness and the distribution of weight on the body may make a bigger difference than actual weight. Concerns about potential weight gain should not stand in the way of making more important health changes, such as smoking cessation.

Group Profile: Your group is better than HP2000 target.



Risk Reduction Objectives

- Exercise
- Reduction of dietary fat
- Increase in dietary fiber
- Behavioral change in food consumption patterns

Related Data

In this group, 62 (72%) reported eating high-fat foods daily or more; 15 (17%) reported seldom eating foods high in fiber.

Blood Pressure

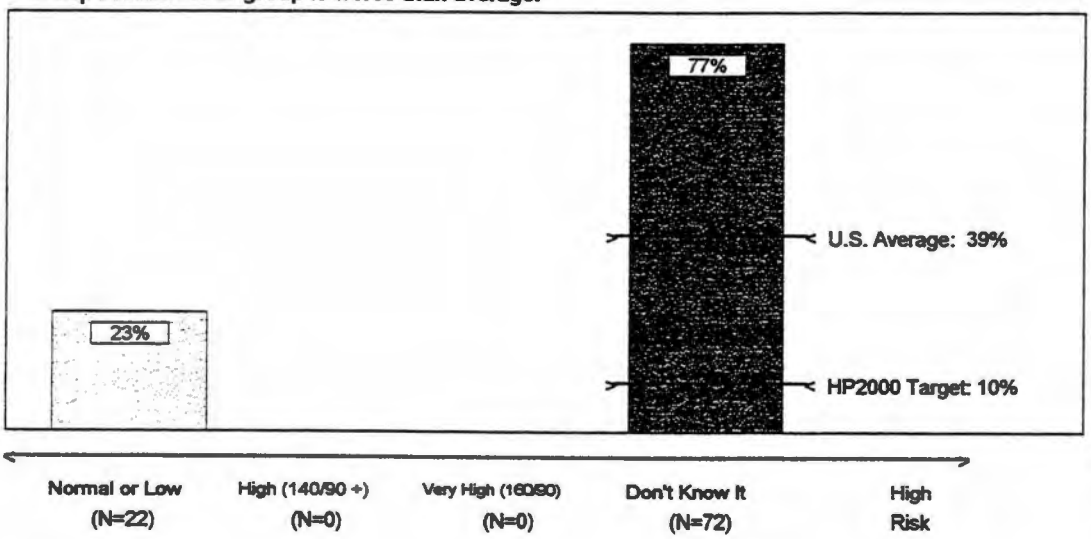
U.S. Average now:
61% know their BP; 35% are over 140/90.

Healthy People 2000 goal:
90% of adults screened and taking action if BP is high.

Ideal:
Everyone screened, those with high values taking action.

As many as 58 million Americans may have hypertension (blood pressure over 140/90). Many of these are unaware of the problem because hypertension by itself has no detectable physical symptoms.

Group Profile: Your group is worse than average.



Risk Reduction Objectives

- Screening for high blood pressure in the group as a whole.
- Prevention -- through exercise, weight control, and a diet low in salt.
- Management of diagnosed hypertension through monitoring, diet, exercise, and possibly drugs.

Related Data

The average for this group is 118/74.

1 (5%) are taking medication to control high blood pressure.

(0%) have very high blood pressure but aren't taking medication for it.

Group Risk Summary

U.S. Average now:

27% are over 240, average is 213 for everyone.

Healthy People 2000 goal:

Under 20% over 240, average for everyone of 200.

Ideal:

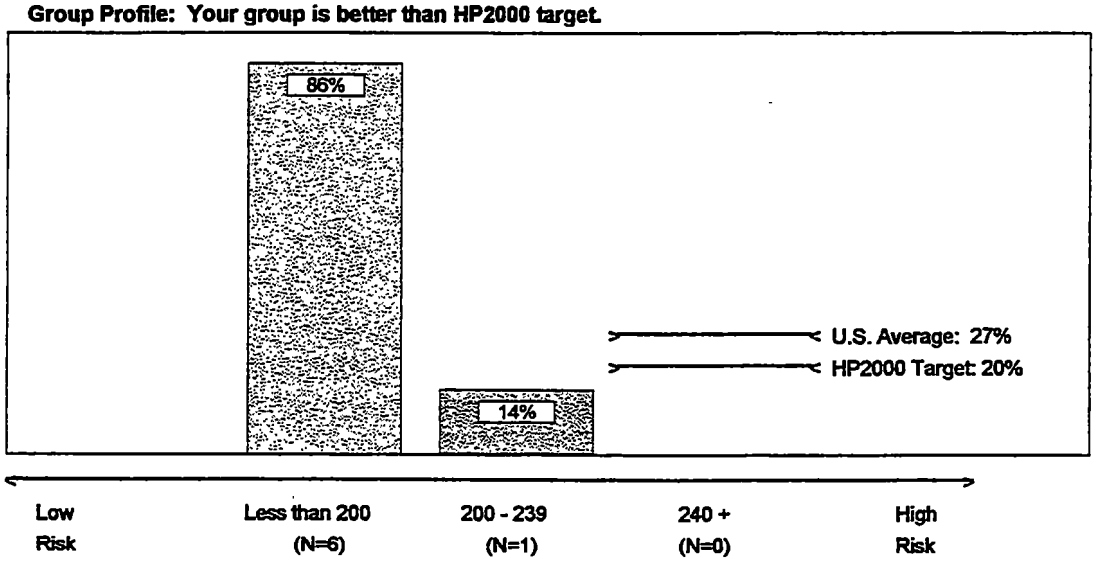
Everyone under 200.

Cholesterol

Blood lipids, including total serum cholesterol and HDL, play an important role in the development of cardiovascular disease.

Many people are confused about "good cholesterol" (HDL) and "bad cholesterol" (LDL) in the blood. There is also misunderstanding about dietary saturated fats, which include cholesterol from animal fats.

Group Profile: Your group is better than HP2000 target.



Risk Reduction Objectives

- Screening of the group as a whole for total serum cholesterol.
- HDL screening as recommended by physician.
- Education about fats in the diet and cholesterol in the bloodstream.
- Increased exercise.
- Reduced saturated fat in the diet.

Related Data

In this group, (0%) knew their HDL.
Average cholesterol is 139.

U.S. Average now:

42% wear seatbelts regularly.

Healthy People 2000 goal:

85% wear seatbelts regularly.

Ideal:

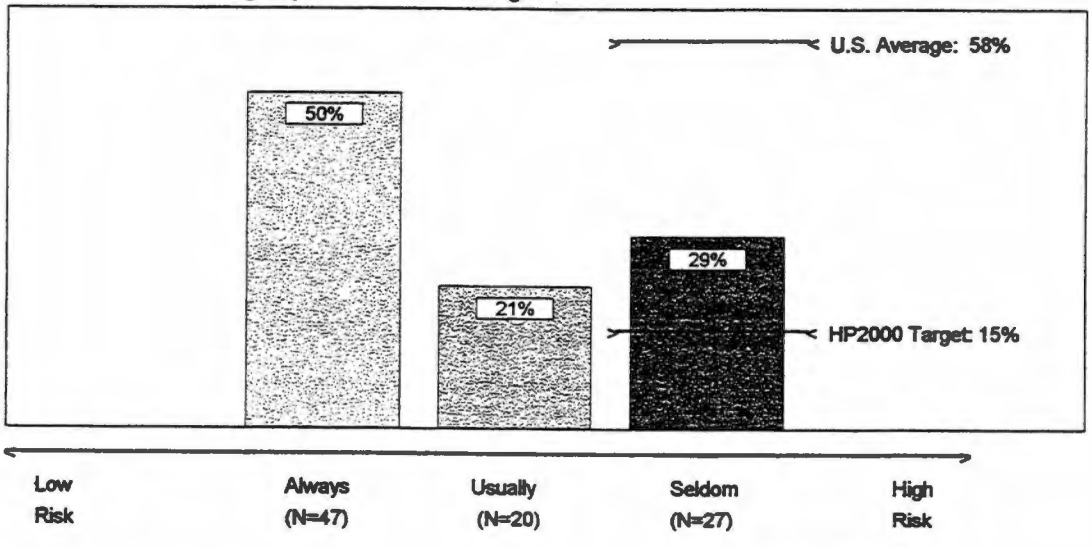
Everyone uses seatbelts regularly.

Seatbelts

The use of seatbelts has increased in recent years, and consistent use is highest where legal enforcement is the most strict.

Some people believe that airbags eliminate the need for seatbelts – not true. Others think seatbelts aren't important in low speed local traffic. In most areas of the country, the majority of injury or fatal accidents occur on surface streets at relatively low speeds, not on high speed freeways.

Group Profile: Your group is better than average.



Risk Reduction Objectives

- Consistent use of lap and shoulder seatbelts on all trips.
- Consistent and correct use of age-appropriate car seats and belts for infants and children.

Related Data

4 (4%) of this group reported often driving 15 MPH or more over the speed limit.

48 (53%) reported driving after drinking (or riding with a drinking driver) at least once in the past month.

U.S. Average now:
8% drink 14+ per week.
13 drinks / week average.

Healthy People 2000 goal:
6% drink 14+ per week.
Under 10 drinks/week average.

Ideal:
No one averages more than 14 drinks per week.

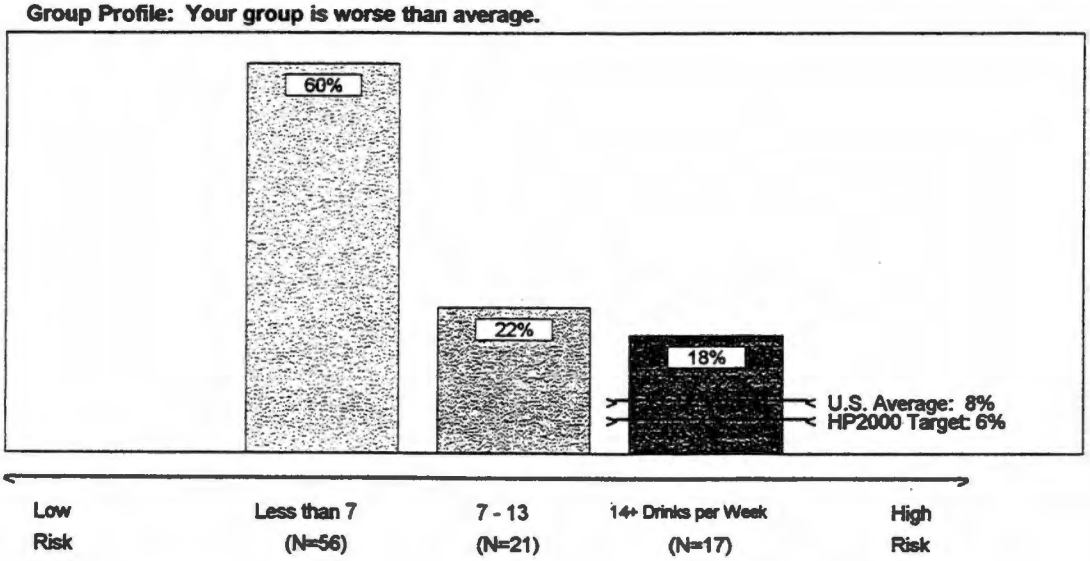
Alcohol

Alcohol is used by over half of all American adults, but it is difficult to estimate how many of these drinkers abuse alcohol.

Alcohol abuse can be drinking too much, drinking at inappropriate times, drinking to avoid issues and responsibilities, and being unable to take control of one's drinking habits.

Alcohol intoxication is involved in about half of all deaths from motor vehicle crashes, fires, drownings, homicides and suicides.

Group Profile: Your group is worse than average.



Risk Reduction Objectives

- No driving and drinking. Encourage designated drivers, alternative transportation, and moderation.
- No drinking during pregnancy.
- Light drinking among non-alcoholic drinkers.
- Abstinence among alcoholics.
- Delays in starting alcohol use among young people.

Related Data

The average for this group is 8 drinks per week.

48 (53%) reported driving after drinking (or riding with a drinking driver) at least once in the past month.

U.S. Average now:
Less than 25% of women over 50 had a mammogram within the past 2 years.

HP2000 goal:
80% of women 50 and older get annual mammograms.

Ideal:
All at recommended intervals.

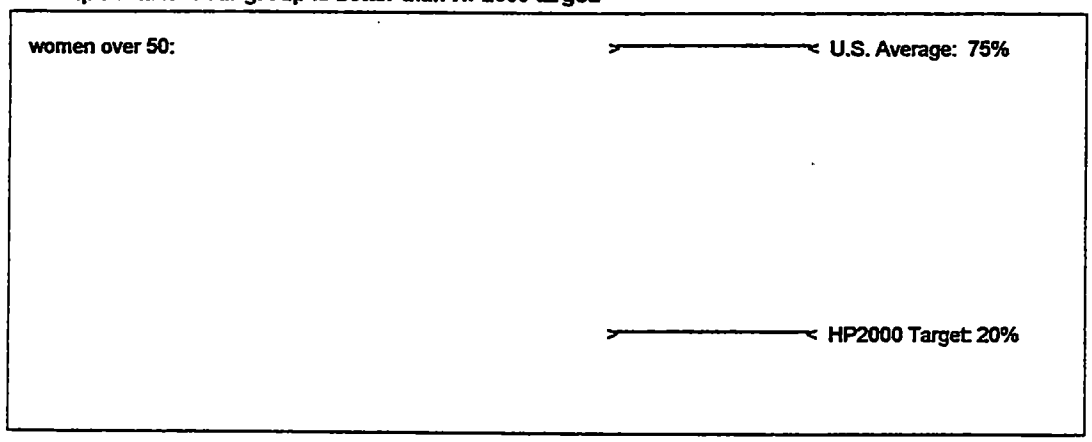
Mammogram

Some healthy practices may help prevent breast cancer from developing. These include a low fat diet and low alcohol consumption. At this point, the best known way to prevent breast cancer deaths rests with early detection.

Mammograms can and do reduce mortality by allowing earlier treatment with a greater chance of success.

Recommended frequency of screening varies with age and other risk factors such as a family history of breast cancer.

Group Profile: Your group is better than HP2000 target.



Risk Reduction Objectives

- First mammogram at physician's recommended age (this varies).
- Regular mammogram schedule thereafter (schedule varies with age and risk factors).

Related Data

The chart shows women age 50 and over. For women age 40-49, (0%) had a mammogram one year ago or less.

(14%) of all women in this group reported doing breast self exams monthly.

U.S. Average now:

56% had a Pap test in the previous year.

Healthy People 2000 goal:

75% of all women getting annual Pap tests.

Ideal:

All women at physician's recommended schedule.

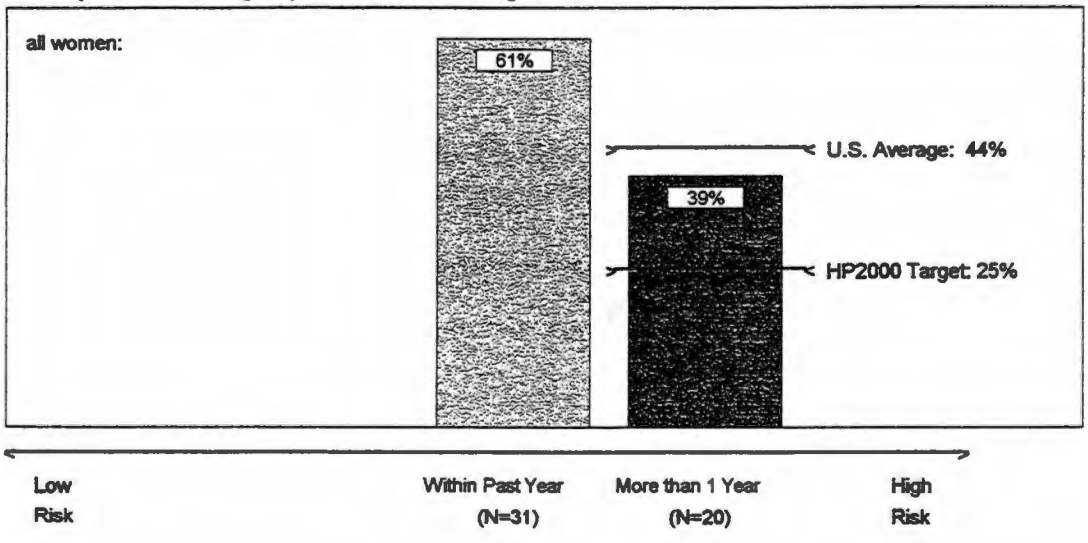
Pap Smear

Pap test screening for cervical cancer greatly reduces the risk of death from cervical cancer. The decline in cervical cancer mortality in the 1970's and 1980's is largely due to increased Pap screening.

A large number of women, especially older women at high risk, still don't have Pap tests at all, or less frequently than recommended.

Recommendations for frequency of screening vary; some advocate annual screening for all women, others claim that less often is sufficient.

Group Profile: Your group is better than average.



Risk Reduction Objectives

- Regularly scheduled Pap tests -- annually or at physician's recommendation.

Demographics

The chart below breaks your group down by age and sex subgroups. There are 115 people in your group; 94 are included in this report.

Although older people face increasingly higher risks of death and disease, young people are also affected by smoking, diet, and safety practices.

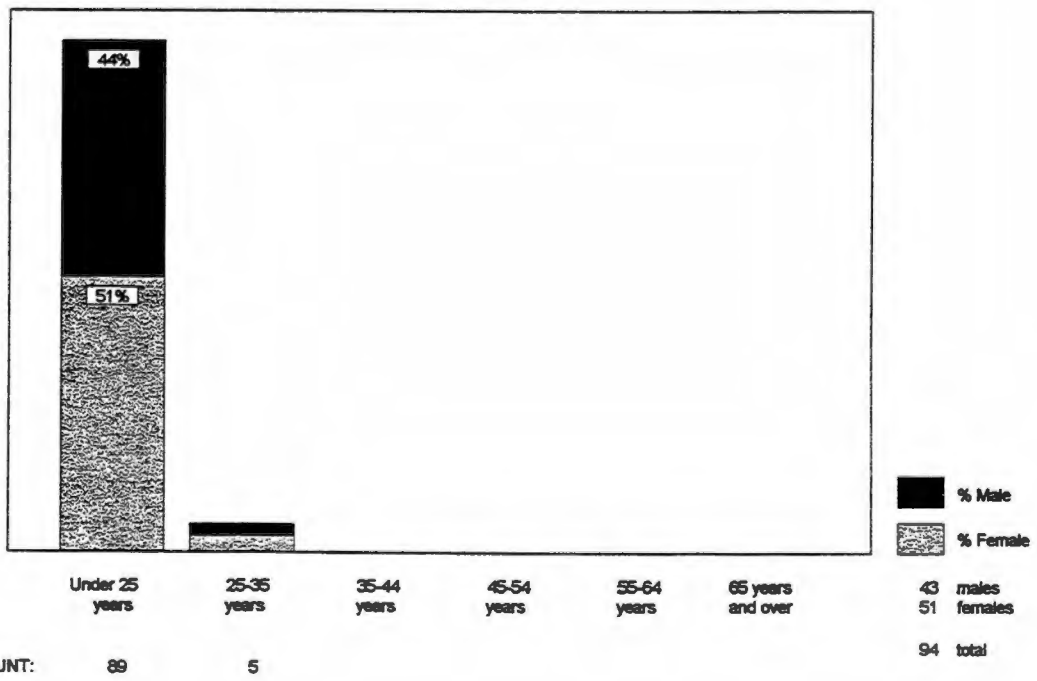
Habits become ingrained during the younger years -- long term physical damage accumulates as well. Although young people have relatively less to fear from major killers such as heart disease and cancer in the short run, they can substantially reduce their lifetime risks by modifying risky habits as soon as possible.

This report contains some sections addressing women's health alone, such as Pap smears and breast examination. The rest of the report is equally applicable to men and women.

It is a common idea that heart disease is primarily a men's disease. This is not so. Until menopause, women have some protection against heart disease. After that time, women are as susceptible to heart attack as men. Heart disease kills more women than any other disease -- twice as many as cancer, for instance.

Health promotion programs make sense -- for people of both sexes and all ages.

Age Groups by Sex



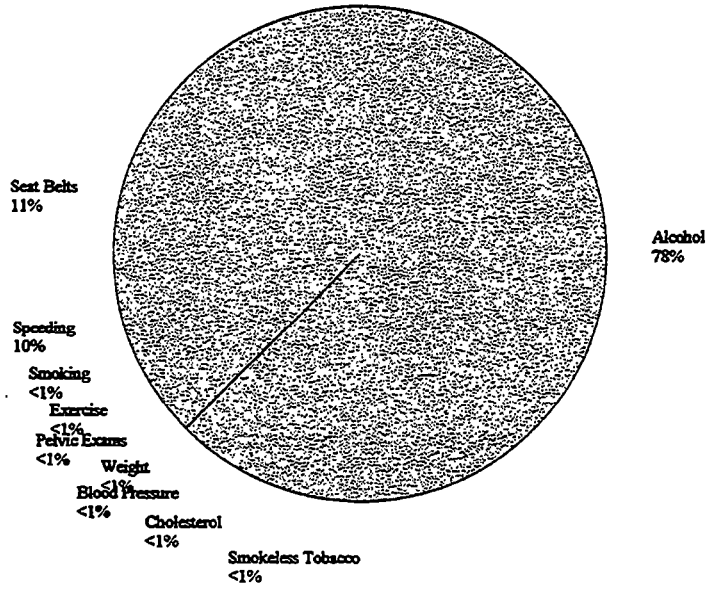
Risk Factors in this Group

Risk factors are conditions that shape the odds for early death and disability. They include habits, such as smoking and lack of exercise, and clinical measures, such as blood pressure and cholesterol.

Nearly half of the 2.15 million deaths in the U.S. in 1990 could have been prevented through behavioral changes.

The chart below shows how each of the risk factors measured by the questionnaire contributes to preventable deaths in your group. These estimates use an algorithm which compares respondents' risk profiles with a national data base of people with similar risk profiles. By looking at the outcomes of similar people, with similar habits, the algorithm projects this group's preventable deaths over the next ten years.

Risk Factors That Contribute to Preventable Deaths in Your Group



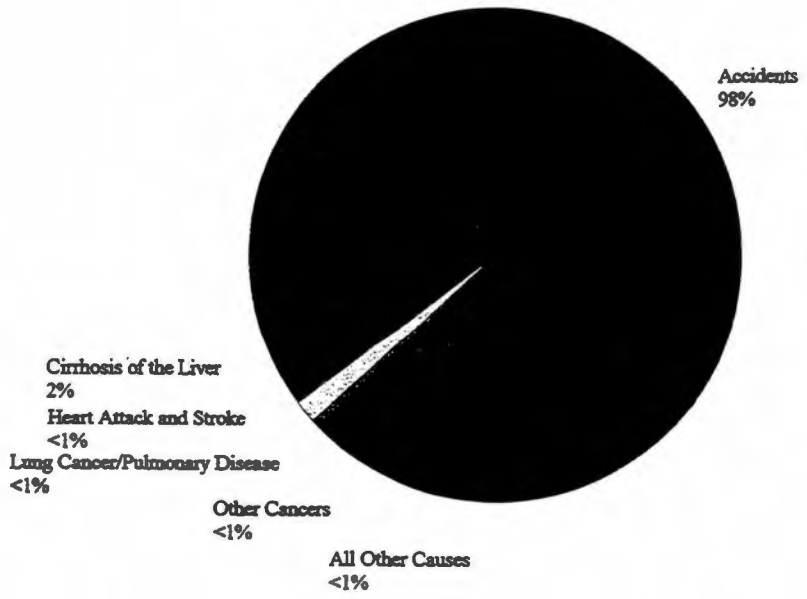
Preventable Causes of Death in this Group

The chart below predicts the relative rank of several major causes of deaths in this group. Please note that the questionnaire and report do not address all areas of health risk, including AIDS risk factors, gun use, and suicidal impulses. These may also be significant causes of death and disability.

Predictions are made for only the next ten year period. This underestimates the total impact of risk factors for heart attack and cancer for young people, because damage can accumulate for years and only result in disease after 20 or 30 years -- not only the ten years reflected in this projection.

Healthy behavior changes made now will reap an even bigger benefit in the years to come.

Preventable Deaths by Disease Category



VITA

Cecilia Watkins was born in West Branch, Michigan, then moved to Kentucky at the age of one. She was raised on her grandparents' farm and went to school at Lewisburg, Kentucky where her grandmother taught the third grade. She graduated from high school at the age of sixteen.

It was seven years before she went to college. Before college, she was married and had two children. In 1982, she got her associate degree from Western Kentucky University, Bowling Green, KY, in business administration and worked six years as a production planner at an aluminum plant. She then returned to Western Kentucky and got a Masters of Science in Health Education. She worked at Florida International University in Miami, Florida, as Senior Health Educator. She then went to Chattanooga, Tennessee to work as the Wellness Consultant for DuPont.

In 1998, Cecilia went to The University of Tennessee, Knoxville, to enter the doctorate program in Health Education. She worked as a graduate teaching associate in the Health Department. She received her Ph.D. in August, 2000.