**Objective:** To demonstrate how simple screening methods can be used to define modifiable lifestyle risk factors in primary care settings and educate clinicians regarding ethnic and gender differences in risk factor profiles.

**Design:** Observational study

**Participants:** 3286 patients (1613 African Americans, 1673 non-Hispanic Whites)

**Intervention:** Lifestyle risk factor assessment using nine-question health habits questionnaire and vital signs measurement

**Main Outcome Measures:** Rates of tobacco use, risky drinking, obesity, and inactivity

**Results:** 29.8% of patients reported tobacco use, 68.9% exercised less than three times per week, 41.1% were obese, and 9.5% screened positive for risky drinking. Whites reported more tobacco use (34.5% vs 24.9%) and risky drinking (10.3% vs 8.8%), while African Americans were more likely to be obese (46.1% vs 36.3%) and inactive (73.2% vs 64.7%). Risky drinking declined in all groups except African American males after age 65.

**Conclusions:** Simple questionnaires and vital signs measurements are useful in screening for modifiable lifestyle risk factors in primary care clinics. Results can be used to identify risk factor patterns in different ethnic, age, and gender groups and to prioritize prevention interventions for individual patients. Simplified methods of assessing overweight and obesity are needed. (Ethn Dis. 2006;16:460–467)

**Key Words:** Risk Factors, Population Groups, Mass Screening, Lifestyle, Primary Health Care

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**INTRODUCTION**

The leading causes of preventable death in the United States are tobacco abuse, unhealthy diet, inactivity, and alcohol abuse, accounting for 38% of preventable deaths.1,2 Tobacco abuse is the leading cause of preventable death in the United States, resulting in ≈440,000 premature deaths and $157 billion in health-related economic losses annually.3 Obesity and inactivity are risk factors for most cardiovascular diseases, some cancers, and degenerative joint disease. Poor diet and physical inactivity lead to 300,000 deaths each year, second only to tobacco use.4 Medical costs associated with physical inactivity in the United States for 2000 were $76.6 billion. The annual cost of obesity is an estimated $117 billion. Data from the 1999–2000 National Health and Nutrition Examination Survey (NHANES) indicate that 64% of US adults are overweight (33%) or obese (31%).5 Results from the Behavioral Risk Factor Surveillance System (BRFSS) 2001 indicate that most US adults are not physically active at a level to promote health, with 50.9% Whites and 63.7% African Americans failing to achieve the recommended level of exercise.6 Modest, regular physical activity substantially reduces the risk of dying of coronary heart disease and reduces the risk for colon cancer, diabetes, and hypertension.7 Physical activity also helps to control weight; contributes to healthy bones, muscles, and joints; helps to relieve the pain of arthritis; and reduces symptoms of anxiety and depression.8 Obesity is associated with many diseases, including hypertension, type 2 diabetes, and metabolic syndrome.9–12 In addition, nearly one third of US adults engage in risky drinking patterns, increasing their risk of alcohol-related trauma and development of alcohol abuse or alcoholism.13 Annual alcohol-related deaths are estimated at 100,000, with a total annual economic cost of $148 billion.14 Because most alcohol-related problems occur in at-risk nondependent drinkers, increasing attention is being given to developing screening programs that detect and address risky drinking, rather than focusing primarily on diagnosis and management of alcohol dependence.15–17

Although US primary care clinics treat large numbers of patients with diseases associated with modifiable lifestyle risk factors, many clinics do not routinely screen for and address lifestyle risk factors. Existing studies provide general US population data on risk factor prevalence; however variations in prevalence at the regional level may be significant and may have implications for individual primary care practices.18 Previous studies indicate that the population of the southern United States is at particularly high risk for cardiovascular disease.19–22 The highest rates of sedentary lifestyle in the United States have been found in rural areas and the southern United States.23 Efforts are underway to create efficient risk factor screening tools for primary care.24,25 Several brief alcohol intervention studies have generated time-efficient clinical tools that gather information about alcohol use while also surveying other health habits such as cigarette smoking, exercise, and weight control.26–29 As part of the Healthy Habits Project, a primary care project designed to increase screening and intervention for modifiable risk factors, we used a simple, nine-item questionnaire, along with measurements of height and weight, to