

Center Number: ____ Participant Number: ____ Participant's Initials: first middle last ____

Phone Screen

Directions: Give the caller a brief overview of the study. Explain that all study details will be made clear during Screening Visit 1. Ask for verbal consent to record personal information over the phone. Complete all phone screen questions in order to determine eligibility. If the caller is eligible, schedule them for Screening Visit 1.
Fill in blanks and check appropriate answers.

Verbal consent given by respondent: ₀ No ₁ Yes Interviewer's initials: first middle last _____

Date: ____/____/____ Source: _____ Age: ____
day month year

Last name: _____ First name: _____ DOB: ____/____/____
day month year

Address: _____ Zip: _____

Phone (home): _____ Phone (work): _____ E-mail: _____

Height: ____ ft ____ in Weight: ____ lbs BMI: _____ Gender: ₁ Male ₂ Female

Medical History

Have you been diagnosed with or ever experienced the following:		If Yes: Describe (being treated/how long ago/symptoms/type of/family history)
Heart attack, heart-related chest pain, or other heart condition	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes →	
Abnormal heart rhythm	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes →	
Cancer	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes →	
Shortness of breath or other breathing problem	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes →	
Diabetes (meds)	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes →	
High blood pressure (> 140/90)	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes →	
Anemia or other blood condition	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes →	
Thyroid or other metabolic disorder such as phenylketonuria	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes →	
Stomach or digestive disorders	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes →	
Immunologic disorder or AIDS	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes →	
Depression or any other psychiatric or neurologic disease	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes →	
Active liver disease and/or gallstones	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes →	
Kidney or urologic disorders	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes →	
Major abdominal or chest surgery	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes →	
Weight loss or gain of > 3 kg over the past 6 months	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes →	
Known metallic objects or implants in your body	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes →	
Anaphylaxis, severe allergies, or asthma	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes →	

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Medications

- 1** Have you received medication for depression or any other psychiatric disease in the past year? ₀ No ₁ Yes → If Yes: Specify medications: _____
- 2** Have you received more than one episode of medication for depression or any other psychiatric disease ever? ₀ No ₁ Yes → If Yes: Specify medications: _____
- 3** Have you been treated with steroids in the last six months? ₀ No ₁ Yes
- 4** Have you been treated with steroids for more than a month in the past five years? ₀ No ₁ Yes
- 5** Do you currently use regular medications other than birth control pills? ₀ No ₁ Yes → If Yes: Specify medications: _____

Women

- 1** Are you currently pregnant or breast feeding? ₀ No ₁ Yes
- 2** Do you plan to have children in the next two years? ₀ No ₁ Yes
- 3** Do you use some form of birth control? ₀ No ₁ Yes → If Yes: Specify: _____

Physical Activity/Lifestyle

- 1** Over the past year, have you engaged in a regular program of physical fitness involving heavy physical activity more than 5 times per week?
(Examples of heavy physical activity include: jogging, running, riding fast on a bicycle for 30 minutes or more; heavy gardening or other chores for an hour or more; active games or sports such as handball or tennis for an hour or more.) ₀ No ₁ Yes → If Yes: Specify type and frequency of activity: _____
- 2** Have you used drugs recreationally within the past two years? ₀ No ₁ Yes
- 3** Have you smoked within the past twelve months? ₀ No ₁ Yes
- 4** Have you given blood in the last 30 days? ₀ No ₁ Yes
- 5** Are you currently participating in another interventional trial? ₀ No ₁ Yes
- 6** Are you currently practicing a vegan dietary lifestyle? ₀ No ₁ Yes
- 7** Do you anticipate difficulties adhering to special diets and clinical visits over a two year period? ₀ No ₁ Yes

Eligibility Information To be completed by the interviewer

Review above items marked "Yes" against Exclusion criteria. Then please mark the appropriate response below:

Eligible: ₀ No → If No: Reason for not being eligible: _____

₁ Yes → If Yes: Is participant interested in participating? ₀ No ₁ Yes

₂ On hold → If on hold: For what reason? _____

Contact to resume screening after being on hold: ____/____/____
day month year

Orientation (screening visit 1) scheduled: _____

Comments: _____

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Screening Visit 1 Checklist

1 Date of initial clinic visit for Screening Visit 1: ____/____/____
day month year

Check completed items:

- 2** Informed consent
- 3** HIPAA authorization
- 4** Study video
- 5** Study brochure
- 6** Weight and height measures, including BMI eligibility
- 7** Demographic form
- 8** Stanford Activity Assessment
- 9** General Dietary Questionnaire
- 10** Eating Inventory
- 11** MAEDS
- 12** SCID-II
- 13** BDI-II
- 14** Meeting with dietitian
- 15** Meeting with study coordinator/manager
- 16** Schedule Assessment Calendar
- 17** Inclusion/Exclusion criteria review
- 18** Is the participant expected to return for Screening Visit 2?
 ₀ No → **If No: Provide reason** (check all that apply):
 - Failed an eligibility criterion
 - Lost interest in the study
 - Will take too much time
 - Scheduling conflicts with work or school
 - Doesn't like the study's procedures
 - Doesn't want to be involved in a research study
 - Unwilling to be randomized
 - Lives too far away/transportation problems
 - Needs help with child care
 - Refused with no explanation
 - Other (specify): _____

₁ Yes → **If Yes: Date of scheduled Screening Visit 2:** ____/____/____
day month year

Fax this Form to DCRI Forms Management at (919) 668-7100

Center Number: ____ Participant Number: ____ Participant's Initials: first middle last

Clinic Weight

Weight date and time: ____/____/____ : ____
day month year 00:00 to 23:59

Staff initials: first middle last

OR Not done → Specify reason (use codelist below): _____

Clinic weight (if the first two measurements are more than 0.1 kg apart, measure weight a third time):

Weight 1: _____ . ____ kg

Weight 2: _____ . ____ kg

Weight 3: _____ . ____ kg

Weight of gown: _____ . ____ kg

Height

Height (if the first two measurements are more than 0.1 cm apart, measure height a third time):

1 First height: _____ . ____ cm

2 Second height: _____ . ____ cm

3 Third height: _____ . ____ cm

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

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Date: ____/____/____
day month year

Maintain completed form in participant file at site.

Please print.

Demographic Questionnaire

Name: _____
first name middle initial last name

Street address: _____

City: _____ State: _____ Zip: _____

Telephone (Home): (____) _____ - _____ (Work): (____) _____ - _____

Do you mind being called at work? No Yes

Best time to call, and where: _____

E-mail address: _____ Cell phone: (____) _____ - _____

Do you use e-mail regularly? No Yes → If Yes: How often? _____

Date of birth: ____/____/____ Age: _____
day month year

Social Security number: _____ - _____ - _____

Occupation: _____

Emergency Contact:

Name: _____
first name last name

Telephone: (____) _____ - _____ Relationship: _____

Primary Care Physician

Name: _____
first name last name

Street address: _____

City: _____ State: _____ Zip: _____

Telephone: (____) _____ - _____ Fax: (____) _____ - _____

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Demographics

1 Date of birth: ____/____/____
day month year

2 Sex: ₁ Male
₂ Female

3 Ethnicity (check only one): ₁ Hispanic or Latino
₂ Not Hispanic or Latino
₃ Unknown (not reporting ethnicity)

4 Race (check only one): ₁ American Indian or Alaska Native
₂ Asian
₃ Native Hawaiian or other Pacific Islander
₄ Black or African American
₅ White
₆ More than one race
₇ Unknown

5 Marital status (check only one): ₁ Married ₄ Widowed
₂ Divorced ₅ Separated
₃ Single, never married ₆ Not married, but living with partner

6 Living situation: Where do you live (check only one): ₁ House
₂ Apartment
₃ Shelter
₄ Dormitory
₉₈ Other (specify): _____

7 Education: What is the highest level of formal education that you have completed (check only one)?

(Note: If you have any questions as to which category you fall in, please contact the study representative.)

- ₁ Elementary school (0-8th grade)
₂ 9-11th grade
₃ 12th grade or GED
₄ Some college/Associates degree
₅ College (includes multiple degrees)
₆ Non-doctoral graduate degree
₇ Doctoral degree (M.D., J.D., Ph.D., etc.)

8 Family income: What is the total annual income of your household (check only one): ₁ \$0-\$19,999
₂ \$20,000-\$39,999
₃ \$40,000-\$59,999
₄ \$60,000-\$79,999
₅ \$80,000-\$99,999
₆ Greater than \$100,000

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Stanford Brief Physical Activity Survey

Section I On-The-Job Activity Please check the box next to the **one** statement that **best** describes the kinds of physical activity you usually performed while on this job this last year. If you are not gainfully employed outside the home but perform work around home **regularly**, indicate that activity in this section.

- A** If you have no job or regular work, check box A and go on to Section II.
- B** I spent most of the day sitting or standing. When I was at work, I did such things as writing, typing, talking on the telephone, assembling small parts, or operating a machine that takes very little exertion or strength. If I drove a car or truck while at work, I did not lift or carry anything for more than a few minutes each day.
- C** I spent most of the day walking or using my hands and arms in work that required moderate exertion. When I was at work, I did such things as delivering mail, patrolling on guard duty, mechanical work on automobiles or other large machines, house painting, or operating a machine that requires some moderate activity work of me. If I drove a truck or lift, my job required me to lift and carry things frequently.
- D** I spent most of the day lifting or carrying heavy objects or moving most of my body in some other way. When I was at work, I did such things as stacking cargo or inventory, handling parts or materials, or I did work like that of a carpenter who builds structures or a gardener who does most of the work without machines.
- E** I spent most of the day doing hard physical labor. When I was at work, I did such things as digging or chopping with heavy tools, or carrying heavy loads (bricks, for example) to the place where they are to be used. If I drove a truck or operated equipment, my job also required me to do hard physical work most of the day with only short breaks.

Section II Leisure-Time Activity Please check the box next to the **one** statement that **best** describes the way you spent your leisure time during most of the last year.

- F** Most of my leisure time was spent without very much physical activity. I mostly did things like watching television, reading or playing cards. If I did anything else, it was likely to be light chores around the house or yard, or some easy-going game like bowling or catch. Only occasionally, no more than once or twice a month, did I do anything more vigorous, like jogging, playing tennis or active gardening.
- G** Weekdays, when I got home from work, I did few active things. But most weekends I was able to get outdoors for some light exercise—going for walks, playing a round of golf (without motorized carts) or doing some active chores around the house.
- H** Three times per week, on the average, I engaged in some moderate activity—such as brisk walking or slow jogging, swimming or riding a bike—for 15–20 minutes or more. Or I spent 45 minutes to an hour or more doing moderately difficult chores—such as raking or washing windows, mowing the lawn or vacuuming—or playing games such as double tennis, or basketball.
- I** During my leisure time over the past year, I engaged in a regular program of physical fitness involving some kind of heavy physical activity at least three times per week. Examples of heavy physical activity are: jogging, running or riding fast on a bicycle for 30 minutes or more; heavy gardening or other chores for an hour or more; active games or sports such as handball or tennis for an hour or more; or a regular program involving calisthenics and jogging or the equivalent for 30 minutes or more.
- J** Over the past year, I engaged in a regular program of physical fitness along the lines described in the last paragraph (I) but I did it almost **daily**—five or more times per week.

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Date completed: ____/____/____ OR Not done → Specify reason (use codelist below): _____
day month year

Eating Inventory

1 When I smell a sizzling steak or see a juicy piece of meat, I find it very difficult to keep from eating, even if I have just finished a meal. ₁ True ₀ False

2 I usually eat too much at social occasions, like parties and picnics. ₁ True ₀ False

3 I am usually so hungry that I eat more than three times a day. ₁ True ₀ False

4 When I have eaten my quota of calories, I am usually good about not eating anymore. ₁ True ₀ False

5 Dieting is so hard for me because I just get too hungry. ₁ True ₀ False

6 I deliberately take small helpings as a means of controlling my weight. ₁ True ₀ False

7 Sometimes things just taste so good that I keep on eating even when I am no longer hungry. ₁ True ₀ False

8 Since I am often hungry, I sometimes wish that while I am eating, an expert would tell me that I have had enough or that I can have something more to eat. ₁ True ₀ False

9 When I feel anxious, I find myself eating. ₁ True ₀ False

10 Life is too short to worry about dieting. ₁ True ₀ False

11 Since my weight goes up and down, I have gone on reducing diets more than once. ₁ True ₀ False

12 I often feel so hungry that I just have to eat something. ₁ True ₀ False

13 When I am with someone who is overeating, I usually overeat too. ₁ True ₀ False

14 I have a pretty good idea of the number of calories in common food. ₁ True ₀ False

15 Sometimes when I start eating, I just can't seem to stop. ₁ True ₀ False

16 It is not difficult for me to leave something on my plate. ₁ True ₀ False

17 At certain times of the day, I get hungry because I have gotten used to eating then. ₁ True ₀ False

18 While on a diet, if I eat food that is not allowed, I consciously eat less for a period of time to make up for it. ₁ True ₀ False

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Eating Inventory (continued)

- 19 Being with someone who is eating often makes me hungry to eat also. True False
- 20 When I feel blue, I often overeat. True False
- 21 I enjoy eating too much to spoil it by counting calories or watching my weight. True False
- 22 When I see a real delicacy, I often get so hungry that I have to eat right away. True False
- 23 I often stop eating when I am not really full as a conscious means of limiting the amount I eat. True False
- 24 I get so hungry that my stomach often seems like a bottomless pit. True False
- 25 My weight has hardly changed at all in the last ten years. True False
- 26 I am always hungry so it is hard for me to stop eating before I finish the food on my plate. True False
- 27 When I feel lonely, I console myself by eating. True False
- 28 I consciously hold back at meals in order not to gain weight. True False
- 29 I sometimes get very hungry late in the evening or at night. True False
- 30 I eat anything I want, any time I want. True False
- 31 Without even thinking about it, I take a long time to eat. True False
- 32 I count calories as a conscious means of controlling my weight. True False
- 33 I do not eat some foods because they make me fat. True False
- 34 I am always hungry enough to eat at any time. True False
- 35 I pay a great deal of attention to changes in my figure. True False
- 36 While on a diet, if I eat a food that is not allowed, I often splurge and eat other high calorie foods. True False

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Eating Inventory (continued)

Please check one answer that is most appropriate to you for each question below.

37	How often are you dieting in a conscious effort to control your weight?	<input type="checkbox"/> ₀ Rarely	<input type="checkbox"/> ₁ Sometimes	<input type="checkbox"/> ₂ Usually	<input type="checkbox"/> ₃ Always
38	Would a weight fluctuation of 5 pounds affect the way you live your life?	<input type="checkbox"/> ₀ Rarely	<input type="checkbox"/> ₁ Sometimes	<input type="checkbox"/> ₂ Usually	<input type="checkbox"/> ₃ Always
39	How often do you feel hungry?	<input type="checkbox"/> ₀ Rarely	<input type="checkbox"/> ₁ Sometimes	<input type="checkbox"/> ₂ Usually	<input type="checkbox"/> ₃ Always
40	Do your feelings of guilt about overeating help you to control your food intake?	<input type="checkbox"/> ₀ Rarely	<input type="checkbox"/> ₁ Sometimes	<input type="checkbox"/> ₂ Usually	<input type="checkbox"/> ₃ Always
41	How difficult would it be for you to stop eating halfway through dinner and not eat for the next four hours?	<input type="checkbox"/> ₀ Easy	<input type="checkbox"/> ₂ Moderately difficult	<input type="checkbox"/> ₁ Slightly difficult	<input type="checkbox"/> ₃ Very difficult
42	How conscious are you of what you are eating?	<input type="checkbox"/> ₀ Not at all	<input type="checkbox"/> ₂ Moderately	<input type="checkbox"/> ₁ Slightly	<input type="checkbox"/> ₃ Extremely
43	How frequently do you avoid "stocking up" on tempting foods?	<input type="checkbox"/> ₀ Almost never	<input type="checkbox"/> ₂ Usually	<input type="checkbox"/> ₁ Seldom	<input type="checkbox"/> ₃ Almost always
44	How likely are you to shop for low calorie foods?	<input type="checkbox"/> ₀ Unlikely	<input type="checkbox"/> ₂ Moderately likely	<input type="checkbox"/> ₁ Slightly likely	<input type="checkbox"/> ₃ Very likely
45	Do you eat sensibly in front of others and splurge alone?	<input type="checkbox"/> ₀ Never	<input type="checkbox"/> ₁ Rarely	<input type="checkbox"/> ₂ Often	<input type="checkbox"/> ₃ Always
46	How likely are you to consciously eat slowly in order to cut down on how much you eat?	<input type="checkbox"/> ₀ Unlikely	<input type="checkbox"/> ₂ Moderately likely	<input type="checkbox"/> ₁ Slightly likely	<input type="checkbox"/> ₃ Very likely
47	How frequently do you skip dessert because you are no longer hungry?	<input type="checkbox"/> ₀ Almost never	<input type="checkbox"/> ₂ At least once a week	<input type="checkbox"/> ₁ Seldom	<input type="checkbox"/> ₃ Almost every day
48	How likely are you to consciously eat less than you want?	<input type="checkbox"/> ₀ Unlikely	<input type="checkbox"/> ₂ Moderately likely	<input type="checkbox"/> ₁ Slightly likely	<input type="checkbox"/> ₃ Very likely
49	Do you go on eating binges though you are not hungry?	<input type="checkbox"/> ₀ Never	<input type="checkbox"/> ₂ Sometimes	<input type="checkbox"/> ₁ Rarely	<input type="checkbox"/> ₃ At least once a week
50	To what extent does this statement describe your eating behavior? "I start dieting in the morning, but because of any number of things that happen during the day, by evening I have given up and eat what I want, promising myself to start dieting again tomorrow."	<input type="checkbox"/> ₀ Not like me	<input type="checkbox"/> ₂ Pretty good description of me	<input type="checkbox"/> ₁ Little like me	<input type="checkbox"/> ₃ Describes me perfectly
51	On a scale of 0 to 5, where 0 means no restraint in eating (eating whatever you want, whenever you want it) and 5 means total restraint (constantly limiting food intake and never "giving in"), what number would you give yourself?	<input type="checkbox"/> ₀ Eat whatever you want, whenever you want it	<input type="checkbox"/> ₂ Often eat whatever you want, whenever you want it	<input type="checkbox"/> ₁ Usually eat whatever you want, whenever you want it	<input type="checkbox"/> ₃ Often limit food intake, but often "give in"
		<input type="checkbox"/> ₄ Usually limit food intake, rarely "give in"	<input type="checkbox"/> ₅ Constantly limiting food intake, never "giving in"		

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day month year

Multiaxial Assessment of Eating Disorder Symptoms (MAEDS)

Instructions: Using the scale shown, please rate the following items on a scale from 1 to 7. Please answer as truthfully as possible.

	Never	Very Rarely	Rarely	Sometimes	Often	Very Often	Always
1 Fasting is a good way to lose weight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
2 My sleep isn't as good as it used to be.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
3 I avoid eating for as long as I can.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
4 Certain foods are "forbidden" for me to eat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
5 I can't keep certain foods in my house because I will binge on them.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
6 I can easily make myself vomit.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
7 I can feel that being fat is terrible.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
8 I avoid greasy foods.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
9 It's okay to binge and purge once in a while.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
10 I don't eat certain foods.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
11 I think I am a good person.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
12 My eating is normal.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
13 I can't seem to concentrate lately.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
14 I try to diet by fasting.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
15 I vomit to control my weight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
16 Lately nothing seems enjoyable anymore.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
17 Laxatives help keep you slim.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
18 I don't eat red meat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
19 I eat so rapidly I can't even taste my food.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇

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Multiaxial Assessment of Eating Disorder Symptoms (MAEDS) (continued)

	Never	Very Rarely	Rarely	Some-times	Often	Very Often	Always
20 I do everything I can to avoid being overweight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
21 When I feel bloated, I must do something to rid myself of that feeling.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
22 I overeat too frequently.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
23 It's okay to be overweight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
24 Recently I have felt that I am a worthless person.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
25 I would be very upset if I gained 2 pounds.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
26 I crave sweets and carbohydrates.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
27 I lose control when I eat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
28 Being fat would be terrible.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
29 I have thought seriously about suicide lately.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
30 I don't have any energy anymore.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
31 I eat small portions to control my weight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
32 I eat 3 meals a day.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
33 Lately I have been easily irritated.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
34 Some foods should be totally avoided.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
35 I use laxatives to control my weight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
36 I am terrified by the thought of being overweight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
37 Purging is a good way to lose weight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
38 I avoid fatty foods.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇

Participant's Initials: first middle last ____

Do not submit to DCRI. Retain at site at secure location.

Center Number: ____ Participant Number: ____ Participant's Initials: first middle last _____

Multiaxial Assessment of Eating Disorder Symptoms (MAEDS) (continued)

	Never	Very Rarely	Rarely	Sometimes	Often	Very Often	Always
39 Recently I have felt pretty blue.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
40 I am obsessed with becoming overweight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
41 I don't eat fried foods.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
42 I skip meals.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
43 Fat people are unhappy.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
44 People are too concerned with the way I eat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
45 I feel good when I skip meals.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
46 I avoid foods with sugar.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
47 I hate it when I feel fat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
48 I am too fat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
49 I eat until I am completely stuffed.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
50 I hate to eat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
51 I feel guilty about a lot of things these days.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
52 I'm very careful of what I eat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
53 I can "hold off" and not eat even if I am hungry.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
54 I eat even when I am not hungry.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
55 Fat people are disgusting.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
56 I wouldn't mind gaining a few pounds.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇

Participant's Initials: first middle last _____

Do not submit to DCRI. Retain at site at secure location.

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Date completed: ____/____/____
day month year

Structured Clinical Interview for DSM-IV (SCID-II)

1	Have you avoided jobs or tasks that involved having to deal with a lot of people?	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes
2	Do you avoid getting involved with people unless you are certain they will like you?	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes
3	Do you find it hard to be "open" even with people are you close to?	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes
4	Do you often worry about being criticized or rejected in social situations?	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes
5	Are you usually quiet when you meet new people?	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes
6	Do you believe that you're not as good, as smart, or as attractive as most other people?	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes
7	Are you afraid to try new things?	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes
8	Do you need a lot of advice or reassurance from other before you can make everyday decisions—like what to wear or what to order in a restaurant?	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes
9	Do you depend on other people to handle important areas in your life such as finances, child care, or living arrangements?	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes
10	Do you find it hard to disagree with people even when you think they are wrong?	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes
11	Do you find it hard to start or work on tasks when there is no one to help you?	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes
12	Have you often volunteered to do things that are unpleasant?	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes
13	Do you usually feel uncomfortable when you are by yourself?	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes
14	When a close relationship ends, do you feel you immediately have to find someone else to take care of you?	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes
15	Do you worry a lot about being left alone to take care of yourself?	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes
16	Are you the kind of person who focuses on details, order, and organization or likes to make lists and schedules?	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes
17	Do you have trouble finishing jobs because you spend so much time trying to get things exactly right?	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes
18	Do you or other people feel that you are so devoted to work (or school) that you have no time left for anyone else or for just having fun?	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes
19	Do you have very high standards about what is right and what is wrong?	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes
20	Do you have trouble throwing things out because they might come in handy some day?	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes
21	Is it hard for you to let other people help you unless they agree to do things exactly the way you want?	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes
22	Is it hard for you to spend money on yourself and other people even when you have enough?	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes
23	Are you often so sure you are right that it doesn't matter what other people say?	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes
24	Have other people told you that you are stubborn or rigid?	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes

Participant's Initials: _____
first middle last

Do not submit to DCRI. Retain at site at secure location.

Center Number: ____ Participant Number: ____ Participant's Initials: _____
first middle last

Structured Clinical Interview for DSM-IV (SCID-II) (continued)

- | | | | |
|-----------|--|-----------------------------|------------------------------|
| 25 | When someone asks you to do something that you don't want to do, do you say "yes" but then work slowly or do a bad job? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 26 | If you don't want to do something, do you often just "forget" to do it? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 27 | Do you often feel that other people don't understand you, or don't appreciate how much you do? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 28 | Are you often grumpy and likely to get into arguments? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 29 | Have you found that most of your bosses, teachers, supervisors, doctors, and others who are supposed to know what they are doing really don't? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 30 | Do you often think that it's not fair that other people have more than you do? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 31 | Do you often complain that more than your share of bad things have happened to you? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 32 | Do you often angrily refuse to do what others want and then later feel bad and apologize? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 33 | Do you usually feel unhappy or that life is no fun? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 34 | Do you believe that you are basically an inadequate person and often don't feel good about yourself? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 35 | Do you often put yourself down? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 36 | Do you keep thinking about bad things that have happened in the past or worry about bad things that might happen in the future? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 37 | Do you often judge others harshly and easily find fault with them? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 38 | Do you think that most people are basically no good? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 39 | Do you almost always expect things to turn out badly? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 40 | Do you often feel guilty about things you have or haven't done? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 41 | Do you often have to keep an eye out to stop people from using you or hurting you? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 42 | Do you spend a lot of time wondering if you can trust your friends or the people you work with? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 43 | Do you find that it is best not to let other people know much about you because they will use it against you? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 44 | Do you often detect hidden threats or insults in things people say or do? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 45 | Are you the kind of person who holds grudges or takes a long time to forgive people who have insulted or slighted you? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 46 | Are there many people you can't forgive because they did or said something to you a long time ago? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 47 | Do you often get angry or lash out when someone criticizes or insults you in some way? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 48 | Have you often suspected that your spouse or partner has been unfaithful? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

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Participant's Initials: _____
first middle last

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Structured Clinical Interview for DSM-IV (SCID-II) (continued)

- | | | | |
|-----------|--|-----------------------------|------------------------------|
| 49 | When you are out in public and see people talking, do you often feel that they are talking about you? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 50 | Do you often get the feeling that things that have no special meaning to most people are really meant to give you a message? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 51 | When you are around people, do you often get the feeling that you are being watched or stared at? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 52 | Have you ever felt that you could make things happen just by making a wish or thinking about them? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 53 | Have you had personal experiences with the supernatural? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 54 | Do you believe that you have a "sixth sense" that allows you to know and predict things that others can't? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 55 | Does it often seem that objects or shadows are really people or animals or that noises are actually people's voices? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 56 | Have you had the sense that some person or force is around you, even though you cannot see anyone? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 57 | Do you often see auras or energy fields around people? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 58 | Are there very few people that you're really close to outside of your immediate family? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 59 | Do you often feel nervous when you are with other people? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 60 | Is it NOT important to you whether you have any close relationships? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 61 | Would you almost always rather do things alone than with other people? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 62 | Could you be content without ever being sexually involved with anyone? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 63 | Are there really very few things that give you pleasure? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 64 | Does it NOT matter to you what people think of you? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 65 | Do you find that nothing makes you very happy or very sad? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 66 | Do you like to be the center of attention? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 67 | Do you flirt a lot? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 68 | Do you often find yourself "coming on" to people? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 69 | Do you try to draw attention to yourself by the way you dress or look? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 70 | Do you often make a point of being dramatic and colorful? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 71 | Do you often change your mind about things depending on the people you're with or what you have just read or seen on TV? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 72 | Do you have lots of friends that you are very close to? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

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Participant's Initials: _____
first middle last

Center Number: ____ Participant Number: ____ Participant's Initials:
first middle last

Structured Clinical Interview for DSM-IV (SCID-II) (continued)

- | | | | |
|-----------|--|-----------------------------|------------------------------|
| 73 | Do people often fail to appreciate your very special talents or accomplishments? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 74 | Have people told you that you have too high an opinion of yourself? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 75 | Do you think a lot about the power, fame, or recognition that will be yours someday? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 76 | Do you think a lot about the perfect romance that will be yours someday? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 77 | When you have a problem, do you almost always insist on seeing the top person? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 78 | Do you feel it is important to spend time with people who are special or influential? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 79 | Is it very important to you that people pay attention to you or admire you in some way? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 80 | Do you think that it's not necessary to follow certain rules or social conventions when they get in your way? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 81 | Do you feel that you are the kind of person who deserves special treatment? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 82 | Do you often find it necessary to step on a few toes to get what you want? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 83 | Do you often have to put your needs above other people's? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 84 | Do you often expect other people to do what you ask without question because of who you are? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 85 | Are you NOT really interested in other people's problems or feelings? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 86 | Have people complained to you that you don't listen to them or care about their feelings? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 87 | Are you often envious of others? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 88 | Do you feel that others are often envious of you? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 89 | Do you find that there are very few people that are worth your time and attention? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 90 | Have you often become frantic when you thought that someone you really cared about was going to leave you? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 91 | Do your relationships with people you really care about have lots of extreme ups and downs? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 92 | Have you all of a sudden changed your sense of who you are and where you are headed? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 93 | Does your sense of who you are often change dramatically? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 94 | Are you different with different people or in different situations, so that you sometimes don't know who you really are? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 95 | Have there been lots of sudden changes in your goals, career plans, religious beliefs, and so on? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 96 | Have you often done things impulsively? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 97 | Have you tried to hurt or kill yourself or threatened to do so? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 98 | Have you ever cut, burned, or scratched yourself on purpose? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

Participant's Initials:
first middle last

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Center Number: ____ Participant Number: ____ Participant's Initials: first middle last _____

Structured Clinical Interview for DSM-IV (SCID-II) (continued)

- 99** Do you have a lot of sudden mood changes? ₀ No ₁ Yes
- 100** Do you often feel empty inside? ₀ No ₁ Yes
- 101** Do you often have temper outbursts or get so angry that you lose control? ₀ No ₁ Yes
- 102** Do you hit people or throw things when you get angry? ₀ No ₁ Yes
- 103** Do even little things get you very angry? ₀ No ₁ Yes
- 104** When you are under a lot of stress, do you get suspicious of other people or feel especially spaced out? ₀ No ₁ Yes
- 105** Before you were 15, would you bully or threaten other kids? ₀ No ₁ Yes
- 106** Before you were 15, would you start fights? ₀ No ₁ Yes
- 107** Before you were 15, did you hurt or threaten someone with a weapon, like a bat, brick, broken bottle, knife, or gun? ₀ No ₁ Yes
- 108** Before you were 15, did you deliberately torture someone or cause someone physical pain and suffering? ₀ No ₁ Yes
- 109** Before you were 15, did you torture or hurt animals on purpose? ₀ No ₁ Yes
- 110** Before you were 15, did you rob, mug, or forcibly take something from someone by threatening him or her? ₀ No ₁ Yes
- 111** Before you were 15, did you force someone to have sex with you, to get undressed in front of you, or to touch you sexually? ₀ No ₁ Yes
- 112** Before you were 15, did you set fires? ₀ No ₁ Yes
- 113** Before you were 15, did you deliberately destroy things that weren't yours? ₀ No ₁ Yes
- 114** Before you were 15, did you break into houses, other buildings, or cars? ₀ No ₁ Yes
- 115** Before you were 15, did you lie a lot or "con" other people? ₀ No ₁ Yes
- 116** Before you were 15, did you sometimes steal or shoplift things or forge someone's signature? ₀ No ₁ Yes
- 117** Before you were 15, did you run away from home and stay away overnight? ₀ No ₁ Yes
- 118** Before you were 13, did you often stay out very late, long after the time you were supposed to be home? ₀ No ₁ Yes
- 119** Before you were 13, did you often skip school? ₀ No ₁ Yes

Participant's Initials: first middle last _____

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Center Number: ____ Participant Number: ____ Participant's Initials: first middle last

Date completed: ____/____/____
day month year

BDI-II

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully and then pick out the one statement in each group that best describes the way you have been feeling during the past two weeks, including today. Check the box beside the statement you have picked. Be sure that you check only one statement for each group, including item 16 and item 18.

- 1 Sadness:**
- ₀ I do not feel sad
 - ₁ I feel sad much of the time
 - ₂ I am sad all of the time
 - ₃ I am so sad or unhappy that I can't stand it
- 2 Pessimism:**
- ₀ I am not discouraged about my future
 - ₁ I feel more discouraged about my future than I used to be
 - ₂ I do not expect things to work out for me
 - ₃ I feel my future is hopeless and will only get worse
- 3 Past failure:**
- ₀ I do not feel like a failure
 - ₁ I have failed more than I should have
 - ₂ As I look back, I see a lot of failures
 - ₃ I feel I am a total failure as a person
- 4 Loss of pleasure:**
- ₀ I get as much pleasure as I ever did from the things I enjoy
 - ₁ I don't enjoy things as much as I used to
 - ₂ I get very little pleasure from the things I used to enjoy
 - ₃ I can't get any pleasure from the things I used to enjoy
- 5 Guilty feelings:**
- ₀ I don't feel particularly guilty
 - ₁ I feel guilty over many things I have done or should have done
 - ₂ I feel quite guilty most of the time
 - ₃ I feel guilty all of the time
- 6 Punishment feelings:**
- ₀ I don't feel I am being punished
 - ₁ I feel I may be punished
 - ₂ I expect to be punished
 - ₃ I feel I am being punished
- 7 Self-dislike:**
- ₀ I feel the same about myself as ever
 - ₁ I have lost confidence in myself
 - ₂ I am disappointed in myself
 - ₃ I dislike myself

Participant's Initials: first middle last

Do not submit to DCRI. Retain at site at secure location.

Center Number: ____ Participant Number: ____ Participant's Initials:
first middle last

BDI-II (continued)

- 8 Self-criticalness:**
- ₀ I don't criticize or blame myself more than usual
 - ₁ I am more critical of myself than I used to be
 - ₂ I criticize myself for all of my faults
 - ₃ I blame myself for everything bad that happens
- 9 Suicidal thoughts or wishes:**
- ₀ I don't have any thoughts of killing myself
 - ₁ I have thoughts of killing myself but I would not carry them out
 - ₂ I would like to kill myself
 - ₃ I would kill myself if I had the chance
- 10 Crying:**
- ₀ I don't cry any more than I used to
 - ₁ I cry more than I used to
 - ₂ I cry over every little thing
 - ₃ I feel like crying, but I can't
- 11 Agitation:**
- ₀ I am no more wound up or restless than usual
 - ₁ I feel more restless or wound up than usual
 - ₂ I am so restless or agitated that it's hard to stay still
 - ₃ I am so restless or agitated that I have to keep moving or doing something
- 12 Loss of interest:**
- ₀ I have not lost interest in other people or activities
 - ₁ I am less interested in other people or things than before
 - ₂ I have lost most of my interest in other people or things
 - ₃ It's hard to get interested in anything
- 13 Indecisiveness:**
- ₀ I make decisions about as well as ever
 - ₁ I find it more difficult to make decisions than usual
 - ₂ I have much greater difficulty in making decisions than I used to
 - ₃ I have trouble making my decisions
- 14 Worthlessness:**
- ₀ I do not feel I am worthless
 - ₁ I don't consider myself as worthwhile and useful as I used to
 - ₂ I feel more worthless as compared to other people
 - ₃ I feel utterly worthless
- 15 Loss of energy:**
- ₀ I have as much energy as ever
 - ₁ I have less energy than I used to have
 - ₂ I don't have enough energy to do very much
 - ₃ I don't have enough energy to do anything

Participant's Initials:
first middle last

Do not submit to DCRI. Retain at site at secure location.

Center Number: ____ Participant Number: ____ Participant's Initials: first middle last _____

BDI-II (continued)

- 16 Changes in sleeping pattern:**
- ₀ I have not experienced any change in my sleeping pattern
 - ₁ I sleep somewhat more than usual
 - ₂ I sleep somewhat less than usual
 - ₃ I sleep a lot more than usual
 - ₄ I sleep a lot less than usual
 - ₅ I sleep most of the day
 - ₆ I wake up 1-2 hours early and can't get back to sleep

- 17 Irritability:**
- ₀ I am no more irritable than usual
 - ₁ I am more irritable than usual
 - ₂ I am much more irritable than usual
 - ₃ I am irritable all of the time

- 18 Changes in appetite:**
- ₀ I have not experienced any change in my appetite
 - ₁ My appetite is somewhat less than usual
 - ₂ My appetite is somewhat greater than usual
 - ₃ My appetite is much less than before
 - ₄ My appetite is much greater than usual
 - ₅ I have no appetite at all
 - ₆ I crave food all of the time

- 19 Concentration difficulty:**
- ₀ I can concentrate as well as ever
 - ₁ I can't concentrate as well as usual
 - ₂ It's hard to keep my mind on anything for very long
 - ₃ I find I can't concentrate on anything

- 20 Tiredness or fatigue:**
- ₀ I am no more tired or fatigued than usual
 - ₁ I get more tired or fatigued more easily than usual
 - ₂ I am too tired or fatigued to do a lot of the things I used to do
 - ₃ I am too tired or fatigued to do most of the things I used to do

- 21 Loss of interest in sex:**
- ₀ I have not noticed any recent change in my interest in sex
 - ₁ I am less interested in sex than I used to be
 - ₂ I am much less interested in sex now
 - ₃ I have lost interest in sex completely

Participant's Initials: first middle last _____

Do not submit to DCRI. Retain at site at secure location.

Center Number: ____ Participant Number: ____ Participant's Initials: first middle last ____

Screening Visit 2 Checklist

1 Did participant return for Screening Visit 2?

- No → If No: Skip to question 15 and provide reason.
- Yes → If Yes: Date of initial clinic visit for Screening Visit 2: ____/____/____
day month year

Check completed items:

- 2** Fasting blood sample
- 3** Urine sample
- 4** Vitals (temperature, pulse, blood pressure)
- 5** ECG
- 6** Medical and medication history
- 7** Concomitant medications log
- 8** Physical examination
- 9** Barriers interview
- 10** Body morph assessment
- 11** Additional interviews (SCID-II and/or IDED-IV)
- 12** Meeting with dietitian to review dietary screening questionnaire
- 13** 14-day food record procedure reviewed
- 14** Meeting with study coordinator/manager
- 15 Is the participant expected to return for Screening Visit 3?**
 - No → If No: Provide reason (check all that apply):
 - Failed an eligibility criterion
 - Lost interest in the study
 - Will take too much time
 - Scheduling conflicts with work or school
 - Doesn't like the study's procedures
 - Doesn't want to be involved in a research study
 - Unwilling to be randomized
 - Lives too far away/transportation problems
 - Needs help with child care
 - Refused with no explanation
 - Unable to contact
 - Other (specify): _____
 - Yes → If Yes: Date of scheduled Screening Visit 3: ____/____/____
day month year

Fax this Form to DCRI Forms Management at (919) 668-7100

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Date completed: ____/____/____
day month year

Screening Medical History

List any clinically significant pre-existing condition(s).

Body System	Assessments		
	No	Yes	If Yes, Specify Diagnosis
1 Head, Ears, Eyes, Nose, Throat	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁ →	
2 Dermatologic	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁ →	
3 Cardiovascular	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁ →	
4 Respiratory	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁ →	
5 Gastrointestinal	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁ →	
6 Endocrine/Metabolic	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁ →	
7 Genitourinary	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁ →	
8 Neurological	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁ →	
9 Blood/Lymphatic	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁ →	
10 Musculoskeletal	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁ →	
11 Hepatic	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁ →	
12 Drug Allergies	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁ →	
13 Other Allergies	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁ →	
14 Psychological/Psychiatric	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁ →	
15 Other (including contraception methods, females only)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁ →	

Physician's Signature

Signature: _____ Date: ____/____/____
day month year

Retain this form at site at secure location until participant reassessed at baseline visit.

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Date completed: ____/____/____
day month year

Medication History

Record any medications taken from 6 months prior through screening period, including over-the-counter and prescription drugs, vitamins, supplements, and herbal medications. Include any steroid use within the last 5 years.

Medication	Start Date	Stop Date	Indication
1	____/____/____ <small>day month year</small>	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Continuing	
2	____/____/____ <small>day month year</small>	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Continuing	
3	____/____/____ <small>day month year</small>	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Continuing	
4	____/____/____ <small>day month year</small>	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Continuing	
5	____/____/____ <small>day month year</small>	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Continuing	
6	____/____/____ <small>day month year</small>	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Continuing	
7	____/____/____ <small>day month year</small>	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Continuing	
8	____/____/____ <small>day month year</small>	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Continuing	
9	____/____/____ <small>day month year</small>	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Continuing	
10	____/____/____ <small>day month year</small>	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Continuing	
11	____/____/____ <small>day month year</small>	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Continuing	
12	____/____/____ <small>day month year</small>	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Continuing	

Page Numbering: Sequentially number each page in the right hand corner, i.e. 24.1, 24.2, 24.3. Insert additional pages as needed.

Retain at site at secure location. Submit with Concomitant Medication Log for Baseline Submission 1.

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Physical Examination

Date of examination: ____/____/____ OR Not done → Specify reason (use codelist below): _____
day month year

Body System	Assessments			If Abnormal or Not Done: Explain
	Normal	Abnormal	Not Done	
1 General appearance:	<input type="checkbox"/> _1	<input type="checkbox"/> _0 →	<input type="checkbox"/> _97 →	
2 Head, Ears, Eyes, Nose, Throat:	<input type="checkbox"/> _1	<input type="checkbox"/> _0 →	<input type="checkbox"/> _97 →	
3 Neck:	<input type="checkbox"/> _1	<input type="checkbox"/> _0 →	<input type="checkbox"/> _97 →	
4 Heart:	<input type="checkbox"/> _1	<input type="checkbox"/> _0 →	<input type="checkbox"/> _97 →	
5 Lungs:	<input type="checkbox"/> _1	<input type="checkbox"/> _0 →	<input type="checkbox"/> _97 →	
6 Abdomen:	<input type="checkbox"/> _1	<input type="checkbox"/> _0 →	<input type="checkbox"/> _97 →	
7 Lymph nodes:	<input type="checkbox"/> _1	<input type="checkbox"/> _0 →	<input type="checkbox"/> _97 →	
8 Extremities/Skin:	<input type="checkbox"/> _1	<input type="checkbox"/> _0 →	<input type="checkbox"/> _97 →	
9 Neurological:	<input type="checkbox"/> _1	<input type="checkbox"/> _0 →	<input type="checkbox"/> _97 →	
10 Musculoskeletal:	<input type="checkbox"/> _1	<input type="checkbox"/> _0 →	<input type="checkbox"/> _97 →	
	Normal	Abnormal	Not Done *	
11 Genitourinary:	<input type="checkbox"/> _1	<input type="checkbox"/> _0 →	<input type="checkbox"/> _97 →	
12 Breast:	<input type="checkbox"/> _1	<input type="checkbox"/> _0 →	<input type="checkbox"/> _97 →	

Physician's Signature

Signature: _____ Date: ____/____/____
day month year

* Not done at this examination OR Referred participant to primary care physician for exam.

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Do not submit to DCRI. Retain at site at secure location.

Center Number: ____ Participant Number: ____ Participant's Initials: first middle last ____

Screening Visit 3 Checklist

1 Did participant return for Screening Visit 3?

₀ No → **If No: Skip to question 5 and provide reason.**

₁ Yes → **If Yes: Date of initial clinic visit for Screening Visit 3:** ____ / ____ / ____
day month year

Check completed items:

2 Reviewed all lab results (blood, urine, and pregnancy test)

3 Repeated blood sample, if needed

4 14-day food record collected and reviewed

5 Has the participant been contacted and agreed to additional visit (check only one)?

₀ No, no additional visits → **If No additional visits: Provide reason (check all that apply):**

- Failed an eligibility criterion
- Lost interest in the study
- Will take too much time
- Scheduling conflicts with work or school
- Doesn't like the study's procedures
- Doesn't want to be involved in a research study
- Unwilling to be randomized
- Lives too far away/transportation problems
- Needs help with child care
- Refused with no explanation
- Unable to contact
- Other (specify): _____

₁ Yes → **If Yes: Additional visit scheduled (check only one):**

₁ Screening Visit 4 → **Date of scheduled Screening Visit 4:** ____ / ____ / ____
day month year

₂ Baseline visit → **Date of scheduled Baseline Visit:** ____ / ____ / ____
day month year

Fax this Form to DCRI Forms Management at (919) 668-7100

Center Number: ____ Participant Number: ____ Participant's Initials: first middle last ____

Screening Visit 4 Checklist Optional—Submit this form only if Screening Visit 4 was scheduled

1 Did participant return for Screening Visit 4?

₀ No → **If No: Skip to question 4 and provide reason.**

₁ Yes → **If Yes: Date of initial clinic visit for Screening Visit 4:** ____ / ____ / ____
day month year

Check completed items:

2 Reviewed all lab results (blood, urine, and pregnancy test)

3 14-day food record collected and reviewed (if needed)

4 Has the participant been contacted and agreed to proceed with a Baseline Visit (check only one)?

₀ No → **If No: Provide reason (check all that apply):**

- Failed an eligibility criterion
- Lost interest in the study
- Will take too much time
- Scheduling conflicts with work or school
- Doesn't like the study's procedures
- Doesn't want to be involved in a research study
- Unwilling to be randomized
- Lives too far away/transportation problems
- Needs help with child care
- Refused with no explanation
- Unable to contact
- Other (specify): _____

₁ Yes → **If Yes: Date of scheduled Baseline Visit:** ____ / ____ / ____
day month year

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Informed Consent

1 Did participant present for baseline visit?

- ₀ No → If No: Specify reason (check only one):
- ₁ Failed an eligibility criterion (participant no longer meets criteria)
 - ₂ Lost interest in the study
 - ₃ Will take too much time
 - ₄ Scheduling conflicts with work or school
 - ₅ Doesn't like the study's procedures
 - ₆ Doesn't want to be involved in a research study
 - ₇ Unwilling to be randomized
 - ₈ Lives too far away/transportation problems
 - ₉ Needs help with child care (unanticipated child care needs)
 - ₁₀ Refused with no explanation
 - ₁₁ Unable to contact
 - ₉₈ Other (specify): _____
- ₁ Yes

2 Date and time study baseline informed consent signed: _____ / _____ / _____ : _____
day month year 00:00 to 23:59

Center Number: ____ Participant Number: ____ Participant's Initials: first middle last _____

Informed Consent Detail

Tissue consent:

Sample type	Check only one		
	Participant consent given for future studies by Calerie and external investigators	Participant consent given for future studies by Calerie	Participant consent not given
1 Blood archive	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
2 Urine archive	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
3 Muscle biopsy archive	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
4 Fat biopsy archive	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Clinic Weight

Weight date and time: ____/____/____ 00:00 to 23:59
day month year

Staff initials: _____
first middle last

OR Not done → Specify reason (use Codelist below): _____

Clinic weight (if the first two measurements are more than 0.1 kg apart, measure weight a third time):

Weight 1: _____ . ____ kg

Weight 2: _____ . ____ kg

Weight 3: _____ . ____ kg

Weight of gown: _____ . ____ kg

Vital Signs

Assessment date and time: ____/____/____ 00:00 to 23:59
day month year

If waist measurement not done → Specify reason (use codelist below): _____

1 Natural waist measurement
(if the first two measurements are more than 1.0 cm apart, measure natural waist circumference a third time):

Staff initials: _____
first middle last

Natural waist measurement 1: _____ . ____ cm

Natural waist measurement 2: _____ . ____ cm

Natural waist measurement 3: _____ . ____ cm

2 Umbilical point waist measurement (if the first two measurements are more than 1.0 cm apart, measure umbilical point waist circumference a third time):

Umbilical point waist measurement 1: _____ . ____ cm

Umbilical point waist measurement 2: _____ . ____ cm

Umbilical point waist measurement 3: _____ . ____ cm

3 Pulse: _____ bpm OR Not done → Specify reason (use codelist below): _____

Staff initials: _____
first middle last

4 Temperature: _____ . ____ °C OR Not done → Specify reason (use codelist below): _____

Staff initials: _____
first middle last

5 Respirations: _____ per minute OR Not done → Specify reason (use codelist below): _____

Staff initials: _____
first middle last

6 Blood pressure (check only one): ₁ Left arm ₂ Right arm

Staff initials: _____
first middle last

6a Blood pressure 1: _____ / _____ mm Hg Time: _____ : _____
systolic diastolic 00:00 to 23:59 OR Not done → Specify reason (use codelist below): _____

6b Blood pressure 2: _____ / _____ mm Hg Time: _____ : _____
systolic diastolic 00:00 to 23:59

6c Blood pressure 3: _____ / _____ mm Hg Time: _____ : _____
systolic diastolic 00:00 to 23:59

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

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Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

12-Lead ECG		
Date and Time	Findings	Staff Initials
____ / ____ / ____ : ____ <small>day month year 00:00 to 23:59</small> OR Not done → Specify reason <small>(see codelist below):</small> _____	Is ECG (check only one): <input type="checkbox"/> ₁ Normal <input type="checkbox"/> ₂ Abnormal, not clinically significant (specify): _____ _____ <input type="checkbox"/> ₃ Abnormal, clinically significant (specify): _____ _____	_____ <small>first middle last</small>

Safety Labs			
Date and time of last meal: ____ / ____ / ____ : ____ <small>day month year 00:00 to 23:59</small>			
Date and time of sample collection: ____ / ____ / ____ : ____ <small>day month year 00:00 to 23:59</small>			
Sample	Sample Complete?	If Not Done, Reason <small>(Use codelist below)</small>	Staff Initials
Blood	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	_____	_____ <small>first middle last</small>
Urine	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	_____	_____ <small>first middle last</small>

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Date completed: ____/____/____
day month year

Abbreviated Medical History

List any clinically significant changes occurring since Screening medical history was completed.

Body System	Assessments		
	No Change	Yes	If Yes, Specify Diagnosis
1 Head, Ears, Eyes, Nose, Throat	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁ →	
2 Dermatologic	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁ →	
3 Cardiovascular	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁ →	
4 Respiratory	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁ →	
5 Gastrointestinal	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁ →	
6 Endocrine/Metabolic	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁ →	
7 Genitourinary	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁ →	
8 Neurological	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁ →	
9 Blood/Lymphatic	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁ →	
10 Musculoskeletal	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁ →	
11 Hepatic	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁ →	
12 Drug Allergies	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁ →	
13 Other Allergies	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁ →	
14 Psychological/Psychiatric	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁ →	
15 Other	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁ →	

Physician's Signature

Signature: _____ Date: ____/____/____
day month year

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Physical Examination

Date of examination: ____/____/____
day month year

Staff initials: _____
first middle last

OR Not done → Specify reason (use codelist below): _____

Body System	Assessments			If Abnormal or Not Done: Explain
	Normal	Abnormal	Not Done	
1 General appearance:	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀ →	<input type="checkbox"/> ₉₇ →	
2 Head, Ears, Eyes, Nose, Throat:	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀ →	<input type="checkbox"/> ₉₇ →	
3 Neck:	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀ →	<input type="checkbox"/> ₉₇ →	
4 Heart:	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀ →	<input type="checkbox"/> ₉₇ →	
5 Lungs:	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀ →	<input type="checkbox"/> ₉₇ →	
6 Abdomen:	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀ →	<input type="checkbox"/> ₉₇ →	
7 Lymph nodes:	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀ →	<input type="checkbox"/> ₉₇ →	
8 Extremities/Skin:	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀ →	<input type="checkbox"/> ₉₇ →	
9 Neurological:	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀ →	<input type="checkbox"/> ₉₇ →	
10 Musculoskeletal:	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀ →	<input type="checkbox"/> ₉₇ →	
	Normal	Abnormal	Not Done *	
11 Genitourinary:	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀ →	<input type="checkbox"/> ₉₇ →	
12 Breast:	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀ →	<input type="checkbox"/> ₉₇ →	

Physician's Signature

Investigator: _____
signature

Date: ____/____/____
day month year

* Not done at this examination OR Referred participant to primary care physician for exam.

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

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Center Number: ____ Participant Number: _____ Participant's Initials: first middle last _____

Clinic Weight

Weight date and time: ____/____/____ : ____
day month year 00:00 to 23:59

Staff initials: first middle last _____

OR Not done → Specify reason (use codelist below): ____

Clinic weight (if the two measurements are more than 0.1 kg apart, measure weight a third time):

Weight 1: _____ . ____ kg

Weight 2: _____ . ____ kg

Weight 3: _____ . ____ kg

Weight of gown: _____ . ____ kg

Pregnancy Test

Complete only for females.

Does participant have reproductive potential?

₀ No

₁ Yes → If Yes: Date urine pregnancy test performed: ____/____/____
day month year

Results: ₁ Negative

₂ Positive

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Doubly Labeled Water (DLW)

1 Date and time of DLW dosing: _____ / _____ / _____ : _____
day month year 00:00 to 23:59 Staff initials: _____
first middle last

OR Not done → Specify reason (use codelist below): _____

2 DLW dose mixture ID and bottle number: _____ - _____ - _____ - CA

3 Exact weight of DLW mixture: _____ . _____ grams

4 Urine samples:

Collection	Sample	Date and Time Collected
Pre dosing (PD)	PDa	_____ / _____ / _____ : _____ <small>day month year 00:00 to 23:59</small>
	PDb	_____ / _____ / _____ : _____ <small>day month year 00:00 to 23:59</small>
Day 0 (Visit 2)	D0a	_____ / _____ / _____ : _____ <small>day month year 00:00 to 23:59</small>
	D0b	_____ / _____ / _____ : _____ <small>day month year 00:00 to 23:59</small>
Day 7 (Visit 3)	D7a	_____ / _____ / _____ : _____ <small>day month year 00:00 to 23:59</small>
	D7b	_____ / _____ / _____ : _____ <small>day month year 00:00 to 23:59</small>
Day 14 (Visit 4)	D14a	_____ / _____ / _____ : _____ <small>day month year 00:00 to 23:59</small>
	D14b	_____ / _____ / _____ : _____ <small>day month year 00:00 to 23:59</small>

5 Affix CRF page label(s) corresponding to this urine sample set:

Affix
Label
Here

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: ____ Participant Number: ____ Participant's Initials:
first middle last

DXA Scan

1 Has the participant taken a calcium supplement today?

₀ No ₁ Yes → If Yes: Proceed with scan and document in the Subject Scan Log to inform the QA Center.

2 Were any studies involving barium or radioisotopes performed within 4 weeks prior to the scheduled DXA exam?

₀ No ₁ Yes

DXA Scan		DXA Rescan OR <input type="checkbox"/> ₉₆ NA
Date of scan: ____/____/____ <small>day month year</small>		Date of rescan: ____/____/____ <small>day month year</small>
Area Scanned Check all that apply	If Not Done, Reason (Use codelist below)	Area Scanned Check all that apply
<input type="checkbox"/> Whole body	_____	<input type="checkbox"/> Whole body
<input type="checkbox"/> Forearm	_____	<input type="checkbox"/> Forearm
<input type="checkbox"/> Spine	_____	<input type="checkbox"/> Spine
<input type="checkbox"/> Hip	_____	<input type="checkbox"/> Hip

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Date completed: ____/____/____ OR Not done → Specify reason (use codelist below): _____
day month year

RAND SF-36

Instructions: This survey asks for your views about your health. This information will help keep track of how well you are able to do your usual activities. Please answer every question by placing a check "X" in the appropriate box. If you are unsure about how to answer a question, give the best answer you can.

1 In general, would you say your health is: ₁ Excellent ₂ Very good ₃ Good ₄ Fair ₅ Poor

2 Compared to one year ago, how would you rate your health in general now? ₁ Much better now than 1 year ago
₂ Somewhat better now than 1 year ago
₃ About the same
₄ Somewhat worse now than 1 year ago
₅ Much worse now than 1 year ago

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes, Limited A Lot	Yes, Limited A Little	No, Not Limited At All
--	--------------------	-----------------------	------------------------

3 Vigorous activities , such as running, lifting heavy objects, participating in strenuous sports	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
---	---------------------------------------	---------------------------------------	---------------------------------------

4 Moderate activities , such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
--	---------------------------------------	---------------------------------------	---------------------------------------

5 Lifting or carrying groceries	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
--	---------------------------------------	---------------------------------------	---------------------------------------

6 Climbing several flights of stairs	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
--	---------------------------------------	---------------------------------------	---------------------------------------

7 Climbing one flight of stairs	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
---	---------------------------------------	---------------------------------------	---------------------------------------

8 Bending, kneeling or stooping	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
--	---------------------------------------	---------------------------------------	---------------------------------------

9 Walking more than a mile	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
--	---------------------------------------	---------------------------------------	---------------------------------------

10 Walking several blocks	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
---	---------------------------------------	---------------------------------------	---------------------------------------

11 Walking one block	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
------------------------------------	---------------------------------------	---------------------------------------	---------------------------------------

12 Bathing or dressing yourself	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
--	---------------------------------------	---------------------------------------	---------------------------------------

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Participant's Initials: _____
first middle last

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Center Number: ____ Participant Number: ____ Participant's Initials: ____
first middle last

Rand SF-36 (continued)

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

Yes **No**

13 Cut down on the **amount of time** you spent on work or other activities ₁ ₂

14 **Accomplished less** than you would like ₁ ₂

15 Were limited in the **kind** of work or other activities ₁ ₂

16 Had **difficulty** performing the work or other activities
(for example, it took extra effort) ₁ ₂

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)

Yes **No**

17 Cut down on the **amount of time** you spent on work or other activities ₁ ₂

18 **Accomplished less** than you would like ₁ ₂

19 Didn't do work or other activities as **carefully** as usual ₁ ₂

20 During the **past 4 weeks**, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors or groups?

₁ Not at all
₂ Slightly
₃ Moderately
₄ Quite a bit
₅ Extremely

21 How much **bodily** pain have you had during the **past 4 weeks**?

₁ None
₂ Very mild
₃ Mild
₄ Moderate
₅ Severe
₆ Very severe

22 During the **past 4 weeks**, how much did pain interfere with your normal work (including both work outside the home and housework)?

₁ Not at all
₂ A little bit
₃ Moderately
₄ Quite a bit
₅ Extremely

Participant's Initials: ____
first middle last

Center Number: ____ Participant Number: ____ Participant's Initials: _____
first middle last

RAND SF-36 (continued)

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks...	All of the Time	Most of the Time	A Good Bit of the Time	Some of the Time	A Little of the Time	None of the Time
23 Did you feel full of pep?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
24 Have you been a very nervous person?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
25 Have you felt so down in the dumps that nothing could cheer you up?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
26 Have you felt calm and peaceful?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
27 Did you have a lot of energy?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
28 Have you felt downhearted and blue?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
29 Did you feel worn out?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
30 Have you been a happy person?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
31 Did you feel tired?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
32 During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc)?	All of the Time	Most of the Time	Some of the Time	A Little of the Time	None of the Time	
	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	
How true or false is each of the following statements for you?	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False	
33 I seem to get sick a little easier than other people.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	
34 I am healthy as anybody I know.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	
35 I expect my health to get worse.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	
36 My health is excellent.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	

Participant's Initials: _____
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Center Number: ____ Participant Number: ____ Participant's Initials: first middle last ____

Date: ____/____/____ OR Not done → Specify reason (use codelist below): ____
day month year

BDI-II

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully and then pick out the one statement in each group that best describes the way you have been feeling during the past two weeks, including today. Check the box beside the statement you have picked. Be sure that you check only one statement for each group, including item 16 and item 18.

- 1 Sadness:** ₀ I do not feel sad
₁ I feel sad much of the time
₂ I am sad all of the time
₃ I am so sad or unhappy that I can't stand it
- 2 Pessimism:** ₀ I am not discouraged about my future
₁ I feel more discouraged about my future than I used to be
₂ I do not expect things to work out for me
₃ I feel my future is hopeless and will only get worse
- 3 Past failure:** ₀ I do not feel like a failure
₁ I have failed more than I should have
₂ As I look back, I see a lot of failures
₃ I feel I am a total failure as a person
- 4 Loss of pleasure:** ₀ I get as much pleasure as I ever did from the things I enjoy
₁ I don't enjoy things as much as I used to
₂ I get very little pleasure from the things I used to enjoy
₃ I can't get any pleasure from the things I used to enjoy
- 5 Guilty feelings:** ₀ I don't feel particularly guilty
₁ I feel guilty over many things I have done or should have done
₂ I feel quite guilty most of the time
₃ I feel guilty all of the time
- 6 Punishment feelings:** ₀ I don't feel I am being punished
₁ I feel I may be punished
₂ I expect to be punished
₃ I feel I am being punished
- 7 Self-dislike:** ₀ I feel the same about myself as ever
₁ I have lost confidence in myself
₂ I am disappointed in myself
₃ I dislike myself

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Participant's Initials: first middle last ____

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Center Number: ____ Participant Number: ____ Participant's Initials: first middle last _____

BDI-II (continued)

- 8 Self-criticalness:**
- ₀ I don't criticize or blame myself more than usual
 - ₁ I am more critical of myself than I used to be
 - ₂ I criticize myself for all of my faults
 - ₃ I blame myself for everything bad that happens
- 9 Suicidal thoughts or wishes:**
- ₀ I don't have any thoughts of killing myself
 - ₁ I have thoughts of killing myself but I would not carry them out
 - ₂ I would like to kill myself
 - ₃ I would kill myself if I had the chance
- 10 Crying:**
- ₀ I don't cry any more than I used to
 - ₁ I cry more than I used to
 - ₂ I cry over every little thing
 - ₃ I feel like crying, but I can't
- 11 Agitation:**
- ₀ I am no more wound up or restless than usual
 - ₁ I feel more restless or wound up than usual
 - ₂ I am so restless or agitated that it's hard to stay still
 - ₃ I am so restless or agitated that I have to keep moving or doing something
- 12 Loss of interest:**
- ₀ I have not lost interest in other people or activities
 - ₁ I am less interested in other people or things than before
 - ₂ I have lost most of my interest in other people or things
 - ₃ It's hard to get interested in anything
- 13 Indecisiveness:**
- ₀ I make decisions about as well as ever
 - ₁ I find it more difficult to make decisions than usual
 - ₂ I have much greater difficulty in making decisions than I used to
 - ₃ I have trouble making my decisions
- 14 Worthlessness:**
- ₀ I do not feel I am worthless
 - ₁ I don't consider myself as worthwhile and useful as I used to
 - ₂ I feel more worthless as compared to other people
 - ₃ I feel utterly worthless
- 15 Loss of energy:**
- ₀ I have as much energy as ever
 - ₁ I have less energy than I used to have
 - ₂ I don't have enough energy to do very much
 - ₃ I don't have enough energy to do anything

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Center Number: ____ Participant Number: ____ Participant's Initials:
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BDI-II (continued)

- 16 Changes in sleeping pattern:**
- ₀ I have not experienced any change in my sleeping pattern
 - ₁ I sleep somewhat more than usual
 - ₂ I sleep somewhat less than usual
 - ₃ I sleep a lot more than usual
 - ₄ I sleep a lot less than usual
 - ₅ I sleep most of the day
 - ₆ I wake up 1-2 hours early and can't get back to sleep

- 17 Irritability:**
- ₀ I am no more irritable than usual
 - ₁ I am more irritable than usual
 - ₂ I am much more irritable than usual
 - ₃ I am irritable all of the time

- 18 Changes in appetite:**
- ₀ I have not experienced any change in my appetite
 - ₁ My appetite is somewhat less than usual
 - ₂ My appetite is somewhat greater than usual
 - ₃ My appetite is much less than before
 - ₄ My appetite is much greater than usual
 - ₅ I have no appetite at all
 - ₆ I crave food all of the time

- 19 Concentration difficulty:**
- ₀ I can concentrate as well as ever
 - ₁ I can't concentrate as well as usual
 - ₂ It's hard to keep my mind on anything for very long
 - ₃ I find I can't concentrate on anything

- 20 Tiredness or fatigue:**
- ₀ I am no more tired or fatigued than usual
 - ₁ I get more tired or fatigued more easily than usual
 - ₂ I am too tired or fatigued to do a lot of the things I used to do
 - ₃ I am too tired or fatigued to do most of the things I used to do

- 21 Loss of interest in sex:**
- ₀ I have not noticed any recent change in my interest in sex
 - ₁ I am less interested in sex than I used to be
 - ₂ I am much less interested in sex now
 - ₃ I have lost interest in sex completely

Participant's Initials:
first middle last

Center Number: ____ Participant Number: _____ Participant's Initials:
first middle last

Date completed: ____/____/____ OR Not done → Specify reason (use codelist below): _____
day month year

Profile of Mood States

Instructions: Please describe **how you feel right now** by checking one box for each of the words listed below.

Feeling	Not At All	A Little	Moderately	Quite A Bit	Extremely
1 Friendly	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
2 Tense	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
3 Angry	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
4 Worn out	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
5 Unhappy	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
6 Clear-headed	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
7 Lively	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
8 Confused	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
9 Sorry for things done	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
10 Shaky	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
11 Listless	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
12 Peeved	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
13 Considerate	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
14 Sad	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
15 Active	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
16 On edge	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
17 Grouchy	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
18 Blue	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
19 Energetic	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
20 Panicky	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

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Center Number: ____ Participant Number: ____ Participant's Initials:
first middle last

Profile of Mood States (continued)

Feeling	Not At All	A Little	Moderately	Quite A Bit	Extremely
21 Hopeless	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
22 Relaxed	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
23 Unworthy	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
24 Spiteful	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
25 Sympathetic	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
26 Uneasy	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
27 Restless	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
28 Unable to concentrate	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
29 Fatigued	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
30 Helpful	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
31 Annoyed	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
32 Discouraged	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
33 Resentful	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
34 Nervous	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
35 Lonely	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
36 Miserable	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
37 Muddled	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
38 Cheerful	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
39 Bitter	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
40 Exhausted	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
41 Anxious	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
42 Ready to fight	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
43 Good-natured	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

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Participant's Initials:
first middle last

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Center Number: ____ Participant Number: ____ Participant's Initials: first middle last _____

Profile of Mood States (continued)

Feeling	Not At All	A Little	Moderately	Quite A Bit	Extremely
44 Gloomy	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
45 Desperate	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
46 Sluggish	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
47 Rebellious	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
48 Helpless	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
49 Weary	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
50 Bewildered	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
51 Alert	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
52 Deceived	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
53 Furious	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
54 Efficient	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
55 Trusting	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
56 Full of pep	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
57 Bad-tempered	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
58 Worthless	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
59 Forgetful	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
60 Carefree	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
61 Terrified	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
62 Guilty	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
63 Vigorous	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
64 Uncertain about things	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
65 Bushed	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

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Perceived Stress Scale (PSS)

Instructions: The questions in this scale ask you about your feelings and thoughts during the last month. In each case, please indicate how often you felt or thought a certain way. Please check only one answer for each question.

	Never	Almost Never	Some- times	Fairly Often	Very Often
1 In the last month, how often have you felt that you were unable to control the important things in your life?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
2 In the last month, how often have you felt confident about your ability to handle your personal problems?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
3 In the last month, how often have you felt that things were going your way?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
4 In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

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Pittsburgh Sleep Quality Index (PSQI)

Instructions: The following questions relate to your usual sleep habits during the past month only. Your answers should indicate the most accurate reply for the majority of days and nights in the past month. Please answer all questions.

During the past month...

1 When have you usually gone to bed? _____ : _____
00:00 to 23:59

2 How long (in minutes) has it taken you to fall asleep each night? _____ minutes

3 When have you usually gotten up in the morning? _____ : _____
00:00 to 23:59

4 How many hours of actual sleep did you get at night?
(This may be different than the number of hours you spend in bed.) ____ . ____ hours

5 During the past month, how often have you had trouble sleeping because you... (check only one answer per question)	Not during the past month	Less than once a week	Once or twice a week	3 or more times a week
a Cannot get to sleep within 30 minutes	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
b Wake up in the middle of the night or early morning	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
c Have to get up to use the bathroom	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
d Cannot breathe comfortably	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
e Cough or snore loudly	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
f Feel too cold	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
g Feel too hot	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
h Have bad dreams	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
i Have pain	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
j Other reason(s), please describe, including how often you have had trouble sleeping because of this reason(s): _____	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
6 During the past month, how often have you taken medicine (prescribed or "over the counter") to help you sleep?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃

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Pittsburgh Sleep Quality Index (PSQI) (continued)

	Never	Once or twice	Once or twice each week	3 or more times each week
7 During the past month, how often have you had trouble staying awake while driving, eating meals, or engaging in social activity?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
	No problem at all	Only a very slight problem	Somewhat of a problem	A very big problem
8 During the past month, how much of a problem has it been for you to keep up enthusiasm to get things done?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
	Very good	Fairly good	Fairly bad	Very bad
9 During the past month, how would you rate your sleep quality overall?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃

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Derogatis Interview for Sexual Function (DISF-SR) (F) Female Version

Instruction: Below you will find a brief set of questions about your sexual activities. The questions are divided into different sections that ask about different aspects of your sexual experiences. One section asks about **sexual fantasies** or daydreams, while another inquires about the kinds of **sexual experiences** that you have. You are also asked about the nature of your **sexual arousal** and the quality of your **orgasm**. There are also a few other questions about different areas of your sexual relationship.

On some questions you are asked to respond in terms of a frequency scale, that is, "how often" do you perform the sexual activities asked about in that section. Some frequency scales go from "0 = not at all" to "8 = four or more times a day." Other frequency scales range from "0 = never" to "4 = always." In the case of other questions, you will be asked to respond in terms of a satisfaction scale. This type of scale tells how much you enjoyed, or were satisfied by the sexual activity being asked about. Some satisfaction scales range from "0 = could not be worse" to "8 = could not be better." Other satisfaction scales go from "0 = not at all satisfied," to "4 = extremely satisfied."

In every section of the inventory the scales required for that section are printed just above the questions so it will be easy to follow. Although it is brief, take your time with the inventory. **For each item, please check the scale number that best describes your personal experience.**

If you have any questions, please ask the person who gave you the inventory for help.

Section 1—Sexual Cognition/Fantasy

During the past 30 days or since the last time you filled out this inventory, how often have you had thoughts, dreams, or fantasies about:	Not at all	Less than 1 per month	1 or 2 per month	1 per week	2 or 3 per week	4 to 6 per week	1 per day	2 or 3 per day	4 or more per day
1.1 A sexually attractive person	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
1.2 Erotic parts of a man's body (e.g., face, shoulders, legs)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
1.3 Erotic or romantic situations	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
1.4 Caressing, touching, undressing, or foreplay	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
1.5 Sexual intercourse, oral sex, touching to orgasm	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈

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Derogatis Interview for Sexual Function (DISF-SR) (F) Female Version (continued)

Section 2—Sexual Arousal

During the past 30 days or since the last time you filled out this inventory, how often did you have the following experiences?	Not at all	Less than 1 per month	1 or 2 per month	1 per week	2 or 3 per week	4 to 6 per week	1 per day	2 or 3 per day	4 or more per day
2.1 Feel sexually aroused while alone	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
2.2 Actively seek sexual satisfaction	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
2.3 Feel sexually aroused with a partner	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
	Never	Rarely	Sometimes	Usually	Always				
2.4 Have normal lubrication with masturbation	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄				
2.5 Have normal lubrication throughout sexual relations	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄				

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Derogatis Interview for Sexual Function (DISF-SR) (F) Female Version (continued)

Section 3—Sexual Behavior/Experiences

During the past 30 days or since the last time you filled out the inventory, how often did you engage in the following sexual activities?	Not at all	Less than 1 per month	1 or 2 per month	1 per week	2 or 3 per week	4 to 6 per week	1 per day	2 or 3 per day	4 or more per day
3.1 Reading or viewing romantic or erotic books or stories	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
3.2 Masturbation	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
3.3 Casual kissing and petting	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
3.4 Sexual foreplay	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
3.5 Sexual intercourse, oral sex, etc.	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈

Section 4—Orgasm

During the past 30 days or since the last time you filled out this inventory, how satisfied have you been with the following?	Not at all	Slightly	Moderately	Highly	Extremely
4.1 Your ability to have an orgasm	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
4.2 The intensity of your orgasm	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
4.3 The ability to have multiple orgasms (if typical for you)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
4.4 Feelings of closeness and togetherness with your partner	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
4.5 Your sense of control (timing) of your orgasm	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
4.6 Feeling a sense of relaxation and well-being after orgasm	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

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Derogatis Interview for Sexual Function (DISF-SR) (F) Female Version (continued)

Section 5—Drive and Relationship

	Not at all	Less than 1 per month	1 or 2 per month	1 per week	2 or 3 per week	4 to 6 per week	1 per day	2 or 3 per day	4 or more per day
5.1 With the partner of your choice, what would be your ideal frequency of sexual intercourse?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
	Not at all	Slightly	Moderately	Highly	Extremely				
5.2 During this period, how interested have you been in sex?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄				
5.3 During this period, how satisfied have you been with your personal relationship with your sexual partner?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄				
	Could not be worse	Very poor	Poor	Somewhat inadequate	Adequate	Above average	Good	Very good	Could not be better
5.4 In general, what would represent the best description of the quality of your sexual functioning?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈

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Derogatis Interview for Sexual Function (DISF-SR) (M) Male Version

Instruction: Below you will find a brief set of questions about your sexual activities. The questions are divided into different sections that ask about different aspects of your sexual experiences. One section asks about **sexual fantasies** or daydreams, while another inquires about the kinds of **sexual experiences** that you have. You are also asked about the nature of your **sexual arousal** and the quality of your **orgasm**. There are also a few other questions about different areas of your sexual relationship.

On some questions you are asked to respond in terms of a frequency scale, that is, "how often" do you perform the sexual activities asked about in that section. Some frequency scales go from "0 = not at all" to "8 = four or more times a day." Other frequency scales range from "0 = never" to "4 = always." In the case of other questions, you will be asked to respond in terms of a satisfaction scale. This type of scale tells how much you enjoyed, or were satisfied by the sexual activity being asked about. Some satisfaction scales range from "0 = could not be worse" to "8 = could not be better." Other satisfaction scales go from "0 = not at all satisfied," to "4 = extremely satisfied."

In every section of the inventory the scales required for that section are printed just above the questions so it will be easy to follow. Although it is brief, take your time with the inventory. **For each item, please check the scale number that best describes your personal experience.**

If you have any questions, please ask the person who gave you the inventory for help.

Section 1—Sexual Cognition/Fantasy

During the past 30 days or since the last time you filled out this inventory, how often have you had thoughts, dreams, or fantasies about:	Not at all	Less than 1 per month	1 or 2 per month	1 per week	2 or 3 per week	4 to 6 per week	1 per day	2 or 3 per day	4 or more per day
1.1 A sexually attractive person	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
1.2 Erotic parts of a woman's body (e.g., face, genitals, legs)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
1.3 Erotic or romantic situations	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
1.4 Caressing, touching, undressing, or foreplay	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
1.5 Sexual intercourse, oral sex, touching to orgasm	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈

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Derogatis Interview for Sexual Function (DISF-SR) (M) Male Version (continued)

Section 2—Sexual Arousal

During the past 30 days or since the last time you filled out this inventory, how often did you have the following experiences?	Not at all	Less than 1 per month	1 or 2 per month	1 per week	2 or 3 per week	4 to 6 per week	1 per day	2 or 3 per day	4 or more per day
2.1 A full erection upon awakening	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
2.2 A full erection during a sexual fantasy or daydream	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
2.3 A full erection while looking at a sexually arousing person, movie, or picture	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
2.4 A full erection during masturbation	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
2.5 A full erection throughout the phases of a normal sexual response cycle, that is from undressing and foreplay through intercourse and orgasm	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈

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Derogatis Interview for Sexual Function (DISF-SR) (M) Male Version (continued)

Section 3—Sexual Behavior/Experiences

During the past 30 days or since the last time you filled out the inventory, how often did you engage in the following sexual activities?	Not at all	Less than 1 per month	1 or 2 per month	1 per week	2 or 3 per week	4 to 6 per week	1 per day	2 or 3 per day	4 or more per day
3.1 Reading or viewing romantic or erotic books or stories	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
3.2 Masturbation	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
3.3 Casual kissing and petting	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
3.4 Sexual foreplay	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
3.5 Sexual intercourse, oral sex, etc.	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈

Section 4—Orgasm

During the past 30 days or since the last time you filled out this inventory, how <u>satisfied</u> have you been with the following?	Not at all	Slightly	Moderately	Highly	Extremely
4.1 Your ability to have an orgasm	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
4.2 The intensity of your orgasm	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
4.3 The length or duration of your orgasm	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
4.4 The amount of seminal liquid that you ejaculate	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
4.5 Your sense of control (timing) of your orgasm	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
4.6 Feeling a sense of relaxation and well-being after orgasm	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

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Derogatis Interview for Sexual Function (DISF-SR) (M) Male Version (continued)

Section 5—Drive and Relationship

	Not at all	Less than 1 per month	1 or 2 per month	1 per week	2 or 3 per week	4 to 6 per week	1 per day	2 or 3 per day	4 or more per day
5.1 With the partner of your choice, what would be your ideal frequency of sexual intercourse?	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4	<input type="checkbox"/> _5	<input type="checkbox"/> _6	<input type="checkbox"/> _7	<input type="checkbox"/> _8
	Not at all	Slightly	Moderately	Highly	Extremely				
5.2 During this period, how interested have you been in sex?	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4				
5.3 During this period, how satisfied have you been with your personal relationship with your sexual partner?	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4				
	Could not be worse	Very poor	Poor	Somewhat inadequate	Adequate	Above average	Good	Very good	Could not be better
5.4 In general, what would represent the best description of the quality of your sexual functioning?	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4	<input type="checkbox"/> _5	<input type="checkbox"/> _6	<input type="checkbox"/> _7	<input type="checkbox"/> _8

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Food Cravings Questionnaire—Trait

Please indicate the extent to which you agree with each statement below, in general, by checking the appropriate box.

	Never OR NA	Rarely	Some- times	Often	Usually	Always
1 Being with someone who is eating often makes me hungry.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
2 When I crave something, I know I won't be able to stop eating once I start.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
3 If I eat what I am craving, I often lose control and eat too much.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
4 I hate it when I give in to cravings.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
5 Food cravings invariably make me think of ways to get what I want to eat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
6 I feel like I have food on my mind all the time.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
7 I often feel guilty for craving certain foods.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
8 I find myself preoccupied with food.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
9 I eat to feel better.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
10 Sometimes, eating makes things seem just perfect.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
11 Thinking about my favorite foods makes my mouth water.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
12 I crave foods when my stomach is empty.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
13 I feel as if my body asks for certain foods.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
14 I get so hungry that my stomach seems like a bottomless pit.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
15 Eating what I crave makes me feel better.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
16 When I satisfy a craving, I feel less depressed.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
17 When I eat what I am craving, I feel guilty about myself.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
18 Whenever I have cravings, I find myself making plans to eat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
19 Eating calms me down.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

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Food Cravings Questionnaire—Trait (continued)

	Never OR NA	Rarely	Some- times	Often	Usually	Always
20 I crave foods when I am bored, angry, or sad.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
21 I feel less anxious after I eat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
22 If I get what I am craving, I cannot stop myself from eating it.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
23 When I crave certain foods, I usually try to eat them as soon as I can.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
24 When I eat what I crave, I feel great.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
25 I have no will power to resist my food crave.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
26 Once I start eating, I have trouble stopping.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
27 I can't stop thinking about eating, no matter how hard I try.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
28 I spend a lot of time thinking about whatever it is I will eat next.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
29 If I give in to a food craving, all control is lost.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
30 When I'm stressed out, I crave food.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
31 I daydream about food.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
32 Whenever I have a food craving, I keep on thinking about eating until I actually eat the food.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
33 If I am craving something, thoughts of eating it consume me.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
34 My emotions often make me want to eat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
35 Whenever I go to a buffet, I end up eating more than what I needed.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
36 It is hard for me to resist the temptation to eat appetizing foods that are in my reach.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
37 When I am with someone who is overeating, I usually overeat too.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
38 When I eat food, I feel comforted.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
39 I crave foods when I'm upset.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆

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Food Cravings Questionnaire—State (FCQ—S)

Below is a list of comments made by people about their eating habits. Please check one answer for each comment that indicates how much you agree with the comment **right now, at this very moment**. Notice that some questions refer to foods in general while others refer to one or more specific foods. Please respond to each item as honestly as possible.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1 I have an intense desire to eat [one or more specific foods].	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
2 I'm craving [one or more specific foods].	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
3 I have an urge for [one or more specific foods]	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
4 Eating [one or more specific foods] would make things seem just perfect.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
5 If I were to eat what I am craving, I am sure my mood would improve.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
6 Eating [one or more specific foods] would feel wonderful.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
7 If I ate something, I wouldn't feel so sluggish and lethargic.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
8 Satisfying my craving would make me feel less grouchy and irritable.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
9 I would feel more alert if I could satisfy my craving.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
10 If I had [one or more specific foods], I could not stop eating it.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
11 My desire to eat [one or more specific foods] seems overpowering.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
12 I know I'm going to keep on thinking about [one or more specific foods] until I actually have it.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
13 I am hungry.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
14 If I ate right now, my stomach wouldn't feel as empty.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
15 I feel weak because of not eating.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

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Food Craving Inventory (FCI-II)

For each of the foods listed below, please check the appropriate box.

Note: A craving is defined as an intense desire to consume a particular food or food type that is difficult to resist.

Over the past month, how often have you experienced a craving for...	Never	Rarely (once or twice)	Sometimes	Often	Always/Almost Every Day
1 Cake	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
2 Pizza	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
3 Fried chicken	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
4 Gravy	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
5 Sandwich bread	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
6 Sausage	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
7 French fries	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
8 Cinnamon rolls	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
9 Rice	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
10 Hot dog	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
11 Hamburger	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
12 Biscuits	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
13 Ice cream	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
14 Pasta	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
15 Fried fish	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
16 Cookies	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
17 Chocolate	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
18 Pancakes or waffles	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
19 Corn bread	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
20 Chips	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
21 Rolls	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
22 Cereal	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
23 Donuts	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
24 Candy	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
25 Brownies	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
26 Bacon	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
27 Steak	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
28 Baked potato	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

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Eating Inventory

- | | | | |
|----|--|--|---|
| 1 | When I smell a sizzling steak or see a juicy piece of meat, I find it very difficult to keep from eating, even if I have just finished a meal. | <input type="checkbox"/> ₁ True | <input type="checkbox"/> ₀ False |
| 2 | I usually eat too much at social occasions, like parties and picnics. | <input type="checkbox"/> ₁ True | <input type="checkbox"/> ₀ False |
| 3 | I am usually so hungry that I eat more than three times a day. | <input type="checkbox"/> ₁ True | <input type="checkbox"/> ₀ False |
| 4 | When I have eaten my quota of calories, I am usually good about not eating anymore. | <input type="checkbox"/> ₁ True | <input type="checkbox"/> ₀ False |
| 5 | Dieting is so hard for me because I just get too hungry. | <input type="checkbox"/> ₁ True | <input type="checkbox"/> ₀ False |
| 6 | I deliberately take small helpings as a means of controlling my weight. | <input type="checkbox"/> ₁ True | <input type="checkbox"/> ₀ False |
| 7 | Sometimes things just taste so good that I keep on eating even when I am no longer hungry. | <input type="checkbox"/> ₁ True | <input type="checkbox"/> ₀ False |
| 8 | Since I am often hungry, I sometimes wish that while I am eating, an expert would tell me that I have had enough or that I can have something more to eat. | <input type="checkbox"/> ₁ True | <input type="checkbox"/> ₀ False |
| 9 | When I feel anxious, I find myself eating. | <input type="checkbox"/> ₁ True | <input type="checkbox"/> ₀ False |
| 10 | Life is too short to worry about dieting. | <input type="checkbox"/> ₁ True | <input type="checkbox"/> ₀ False |
| 11 | Since my weight goes up and down, I have gone on reducing diets more than once. | <input type="checkbox"/> ₁ True | <input type="checkbox"/> ₀ False |
| 12 | I often feel so hungry that I just have to eat something. | <input type="checkbox"/> ₁ True | <input type="checkbox"/> ₀ False |
| 13 | When I am with someone who is overeating, I usually overeat too. | <input type="checkbox"/> ₁ True | <input type="checkbox"/> ₀ False |
| 14 | I have a pretty good idea of the number of calories in common food. | <input type="checkbox"/> ₁ True | <input type="checkbox"/> ₀ False |
| 15 | Sometimes when I start eating, I just can't seem to stop. | <input type="checkbox"/> ₁ True | <input type="checkbox"/> ₀ False |
| 16 | It is not difficult for me to leave something on my plate. | <input type="checkbox"/> ₁ True | <input type="checkbox"/> ₀ False |
| 17 | At certain times of the day, I get hungry because I have gotten used to eating then. | <input type="checkbox"/> ₁ True | <input type="checkbox"/> ₀ False |
| 18 | While on a diet, if I eat food that is not allowed, I consciously eat less for a period of time to make up for it. | <input type="checkbox"/> ₁ True | <input type="checkbox"/> ₀ False |

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Eating Inventory (continued)

- 19** Being with someone who is eating often makes me hungry to eat also. True False
- 20** When I feel blue, I often overeat. True False
- 21** I enjoy eating too much to spoil it by counting calories or watching my weight. True False
- 22** When I see a real delicacy, I often get so hungry that I have to eat right away. True False
- 23** I often stop eating when I am not really full as a conscious means of limiting the amount I eat. True False
- 24** I get so hungry that my stomach often seems like a bottomless pit. True False
- 25** My weight has hardly changed at all in the last ten years. True False
- 26** I am always hungry so it is hard for me to stop eating before I finish the food on my plate. True False
- 27** When I feel lonely, I console myself by eating. True False
- 28** I consciously hold back at meals in order not to gain weight. True False
- 29** I sometimes get very hungry late in the evening or at night. True False
- 30** I eat anything I want, any time I want. True False
- 31** Without even thinking about it, I take a long time to eat. True False
- 32** I count calories as a conscious means of controlling my weight. True False
- 33** I do not eat some foods because they make me fat. True False
- 34** I am always hungry enough to eat at any time. True False
- 35** I pay a great deal of attention to changes in my figure. True False
- 36** While on a diet, if I eat a food that is not allowed, I often splurge and eat other high calorie foods. True False

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Eating Inventory (continued)

Please check one answer that is most appropriate to you for each question below.

37	How often are you dieting in a conscious effort to control your weight?	<input type="checkbox"/> ₁ Rarely	<input type="checkbox"/> ₂ Sometimes	<input type="checkbox"/> ₃ Usually	<input type="checkbox"/> ₄ Always
38	Would a weight fluctuation of 5 pounds affect the way you live your life?	<input type="checkbox"/> ₁ Rarely	<input type="checkbox"/> ₂ Sometimes	<input type="checkbox"/> ₃ Usually	<input type="checkbox"/> ₄ Always
39	How often do you feel hungry?	<input type="checkbox"/> ₁ Rarely	<input type="checkbox"/> ₂ Sometimes	<input type="checkbox"/> ₃ Usually	<input type="checkbox"/> ₄ Always
40	Do your feelings of guilt about overeating help you to control your food intake?	<input type="checkbox"/> ₁ Rarely	<input type="checkbox"/> ₂ Sometimes	<input type="checkbox"/> ₃ Usually	<input type="checkbox"/> ₄ Always
41	How difficult would it be for you to stop eating halfway through dinner and not eat for the next four hours?	<input type="checkbox"/> ₁ Easy	<input type="checkbox"/> ₂ Slightly difficult	<input type="checkbox"/> ₃ Moderately difficult	<input type="checkbox"/> ₄ Very difficult
42	How conscious are you of what you are eating?	<input type="checkbox"/> ₁ Not at all	<input type="checkbox"/> ₂ Slightly	<input type="checkbox"/> ₃ Moderately	<input type="checkbox"/> ₄ Extremely
43	How frequently do you avoid "stocking up" on tempting foods?	<input type="checkbox"/> ₁ Almost never	<input type="checkbox"/> ₂ Seldom	<input type="checkbox"/> ₃ Usually	<input type="checkbox"/> ₄ Almost always
44	How likely are you to shop for low calorie foods?	<input type="checkbox"/> ₁ Unlikely	<input type="checkbox"/> ₂ Slightly likely	<input type="checkbox"/> ₃ Moderately likely	<input type="checkbox"/> ₄ Very likely
45	Do you eat sensibly in front of others and splurge alone?	<input type="checkbox"/> ₁ Never	<input type="checkbox"/> ₂ Rarely	<input type="checkbox"/> ₃ Often	<input type="checkbox"/> ₄ Always
46	How likely are you to consciously eat slowly in order to cut down on how much you eat?	<input type="checkbox"/> ₁ Unlikely	<input type="checkbox"/> ₂ Slightly likely	<input type="checkbox"/> ₃ Moderately likely	<input type="checkbox"/> ₄ Very likely
47	How frequently do you skip dessert because you are no longer hungry?	<input type="checkbox"/> ₁ Almost never	<input type="checkbox"/> ₂ Seldom	<input type="checkbox"/> ₃ At least once a week	<input type="checkbox"/> ₄ Almost every day
48	How likely are you to consciously eat less than you want?	<input type="checkbox"/> ₁ Unlikely	<input type="checkbox"/> ₂ Slightly likely	<input type="checkbox"/> ₃ Moderately likely	<input type="checkbox"/> ₄ Very likely
49	Do you go on eating binges though you are not hungry?	<input type="checkbox"/> ₁ Never	<input type="checkbox"/> ₂ Rarely	<input type="checkbox"/> ₃ Sometimes	<input type="checkbox"/> ₄ At least once a week
50	To what extent does this statement describe your eating behavior? "I start dieting in the morning, but because of any number of things that happen during the day, by evening I have given up and eat what I want, promising myself to start dieting again tomorrow."	<input type="checkbox"/> ₁ Not like me	<input type="checkbox"/> ₂ Little like me	<input type="checkbox"/> ₃ Pretty good description of me	<input type="checkbox"/> ₄ Describes me perfectly
51	On a scale of 0 to 5, where 0 means no restraint in eating (eating whatever you want, whenever you want it) and 5 means total restraint (constantly limiting food intake and never "giving in"), what number would you give yourself?	<input type="checkbox"/> ₀ Eat whatever you want, whenever you want it	<input type="checkbox"/> ₁ Usually eat whatever you want, whenever you want it	<input type="checkbox"/> ₂ Often eat whatever you want, whenever you want it	<input type="checkbox"/> ₃ Often limit food intake, but often "give in"
		<input type="checkbox"/> ₄ Usually limit food intake, rarely "give in"	<input type="checkbox"/> ₅ Constantly limiting food intake, never "giving in"		

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day month year

Weight Efficacy Lifestyle Questionnaire (WEL)

This form describes some typical eating situations. Everyone has situations which make it very hard for them to keep their weight down. The following are a number of situations relating to eating patterns and attitudes. This form will help you to identify the eating situations which you find the hardest to manage.

Read each situation listed below and decide how confident (or certain) you are that you will be able to resist eating in each of the difficult situations. In other words, pretend that you are in the eating situation right now. On a scale from 0 (not confident) to 9 (very confident), choose ONE number that reflects how confident you feel now about being able to **successfully resist** the desire to eat. Check this number for each item.

I am confident that:	Not confident at all that you can resist the desire to eat					Very confident that you can resist the desire to eat				
	0	1	2	3	4	5	6	7	8	9
1 I can resist eating when I am anxious (nervous).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 I can control my eating on the weekends.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 I can resist eating even when I have to say "no" to others.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 I can resist eating when I feel physically run down.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 I can resist eating when I am watching TV.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 I can resist eating when I am depressed (or down).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7 I can resist eating when there are many different kinds of food available.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8 I can resist eating even when I feel it is impolite to refuse a second helping.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9 I can resist eating even when I have a headache.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Weight Efficacy Lifestyle Questionnaire (WEL) (continued)

I am confident that:	Not confident at all that you can resist the desire to eat					Very confident that you can resist the desire to eat				
	0	1	2	3	4	5	6	7	8	9
10 I can resist eating when I am reading.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 I can resist eating when I am angry (or irritable).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12 I can resist eating even when I am at a party.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13 I can resist eating even when others are pressuring me to eat.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14 I can resist eating when I am in pain.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15 I can resist eating just before going to bed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16 I can resist eating when I have experienced failure.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17 I can resist eating when high-calorie foods are available.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18 I can resist eating even when I think others will be upset if I don't eat.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19 I can resist eating when I feel uncomfortable.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20 I can resist eating when I am happy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Multiaxial Assessment of Eating Disorder Symptoms (MAEDS)

Instructions: Using the scale shown, please rate the following items on a scale from 1 to 7. Please answer as truthfully as possible.

	Never	Very Rarely	Rarely	Some-times	Often	Very Often	Always
1 Fasting is a good way to lose weight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
2 My sleep isn't as good as it used to be.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
3 I avoid eating for as long as I can.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
4 Certain foods are "forbidden" for me to eat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
5 I can't keep certain foods in my house because I will binge on them.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
6 I can easily make myself vomit.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
7 I can feel that being fat is terrible.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
8 I avoid greasy foods.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
9 It's okay to binge and purge once in a while.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
10 I don't eat certain foods.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
11 I think I am a good person.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
12 My eating is normal.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
13 I can't seem to concentrate lately.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
14 I try to diet by fasting.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
15 I vomit to control my weight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
16 Lately nothing seems enjoyable anymore.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
17 Laxatives help keep you slim.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
18 I don't eat red meat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
19 I eat so rapidly I can't even taste my food.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇

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Multiaxial Assessment of Eating Disorder Symptoms (MAEDS) (continued)

	Never	Very Rarely	Rarely	Some-times	Often	Very Often	Always
20 I do everything I can to avoid being overweight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
21 When I feel bloated, I must do something to rid myself of that feeling.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
22 I overeat too frequently.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
23 It's okay to be overweight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
24 Recently I have felt that I am a worthless person.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
25 I would be very upset if I gained 2 pounds.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
26 I crave sweets and carbohydrates.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
27 I lose control when I eat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
28 Being fat would be terrible.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
29 I have thought seriously about suicide lately.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
30 I don't have any energy anymore.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
31 I eat small portions to control my weight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
32 I eat 3 meals a day.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
33 Lately I have been easily irritated.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
34 Some foods should be totally avoided.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
35 I use laxatives to control my weight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
36 I am terrified by the thought of being overweight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
37 Purging is a good way to lose weight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
38 I avoid fatty foods.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇

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Multiaxial Assessment of Eating Disorder Symptoms (MAEDS) (continued)

	Never	Very Rarely	Rarely	Some-times	Often	Very Often	Always
39 Recently I have felt pretty blue.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
40 I am obsessed with becoming overweight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
41 I don't eat fried foods.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
42 I skip meals.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
43 Fat people are unhappy.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
44 People are too concerned with the way I eat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
45 I feel good when I skip meals.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
46 I avoid foods with sugar.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
47 I hate it when I feel fat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
48 I am too fat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
49 I eat until I am completely stuffed.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
50 I hate to eat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
51 I feel guilty about a lot of things these days.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
52 I'm very careful of what I eat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
53 I can "hold off" and not eat even if I am hungry.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
54 I eat even when I am not hungry.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
55 Fat people are disgusting.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
56 I wouldn't mind gaining a few pounds.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇

Participant's Initials: _____
first middle last

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Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Date completed: ____/____/____ OR Not done → Specify reason (use codelist below): _____
day month year

Body Shape Questionnaire (BSQ)

We would like to know how you have been feeling about your appearance over the **past four weeks**. Please read each question and check the box for the appropriate choice. Please answer all the questions.

Over the Past Four Weeks...	Never	Rarely	Sometimes	Often	Very Often	Always
1 Has feeling bored made you brood about your shape?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
2 Have you been so worried about your shape that you have been feeling that you ought to diet?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
3 Have you thought that your thighs, hips, or bottom are too large for the rest of you?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
4 Have you been afraid that you might become fat (or fatter)?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
5 Have you worried about your flesh not being firm enough?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
6 Has feeling full (e.g., after eating a large meal) made you feel fat?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
7 Have you felt so bad about your shape that you have cried?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
8 Have you avoided running because your flesh might wobble?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
9 Has being with thin women/men made you feel self-conscious about your shape?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
10 Have you worried about your thighs spreading out when sitting down?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
11 Has eating even a small amount of food made you feel fat?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
12 Have you noticed the shape of other women/men and felt that your own shape compared unfavorably?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
13 Has thinking about your shape interfered with your ability to concentrate (e.g., while watching TV, reading, listening to conversations)?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
14 Has being naked, such as when taking a bath, made you feel fat?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
15 Have you avoided wearing clothes which make you particularly aware of the shape of your body?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
16 Have you imagined cutting off fleshy areas of your body?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Participant's Initials: _____
first middle last

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Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Body Shape Questionnaire (BSQ) (continued)

Over the Past Four Weeks...	Never	Rarely	Some- times	Often	Very Often	Always
17 Has eating sweets, cakes or other high calorie food made you feel fat?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
18 Have you not gone out on social occasions (e.g., parties) because you have felt bad about your shape?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
19 Have you felt excessively large and rounded?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
20 Have you felt ashamed of your body?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
21 Has worry about your shape made you diet?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
22 Have you felt happiest about your shape when your stomach has been empty?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
23 Have you thought that you are the shape you are because you lack self-control?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
24 Have you worried about other people seeing rolls of flesh around your waist or stomach?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
25 Have you felt that it is not fair that other women/men are thinner than you?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
26 Have you vomited in order to feel thinner?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
27 When in company, have you worried about taking up too much room (e.g., sitting on a sofa or bus seat)?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
28 Have you worried about your flesh being dimply?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
29 Has seeing your reflection (e.g., in a mirror or shop window) made you feel bad about your shape?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
30 Have you pinched areas of your body to see how much fat is there?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
31 Have you avoided situations where people could see your body (e.g., communal changing rooms or swimming pools)?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
32 Have you taken laxatives in order to feel thinner?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
33 Have you been particularly self-conscious about your shape when in the company of other people?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
34 Has worry about your shape made you feel you ought to exercise?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆

Participant's Initials: _____
first middle last

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Center Number: ____ Participant Number: ____ Participant's Initials: first middle last

Clinic Weight

Weight date and time: ____ / ____ / ____ : ____
day month year 00:00 to 23:59

Staff initials: first middle last

OR Not done → Specify reason (use codelist below): ____

Clinic weight (if the two measurements are more than 0.1 kg apart, measure weight a third time):

Weight 1: ____ . ____ kg

Weight 2: ____ . ____ kg

Weight 3: ____ . ____ kg

Weight of gown: ____ . ____ kg

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Seven-Day Physical Activity Recall (PAR)

Today's date: ___/___/___
day month year Day (check only one): Mon Tues Wed Thurs Fri Sat Sun OR Not done → Specify reason (use code/list below): _____

1 Were you employed in the last seven days? No → Skip to question 3 Yes
 Interviewer initials: _____
first middle last

2 If Yes: Which days (check all that apply)?
 Mon Tues Wed Thurs Fri Sat Sun

3 Which days do you consider your weekend, or non-work, days?
 Mon Tues Wed Thurs Fri Sat Sun

Day of Week	Date	Sleep Time		Work Time			Morning (in minutes)			Afternoon (in minutes)			Evening (in minutes)		
		In Bed	Up	Start	Stop	Mod.	Hard	Very Hard	Mod.	Hard	Very Hard	Mod.	Hard	Very Hard	
7 <small>(yester-day)</small>	___/___/___ <small>day month year</small>	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	
6	___/___/___ <small>day month year</small>	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	
5	___/___/___ <small>day month year</small>	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	
4	___/___/___ <small>day month year</small>	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	
3	___/___/___ <small>day month year</small>	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	
2	___/___/___ <small>day month year</small>	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	
1 <small>(1 week ago)</small>	___/___/___ <small>day month year</small>	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: ____ Participant Number: ____ Participant's Initials: first middle last ____

Seven-Day Physical Activity Recall (PAR) (continued)

4 Compared to your physical activity over the past three months, was last week's physical activity more, less, or about the same (check only one)?

- ₁ More
₂ Less
₃ About the same

Interviewer: Please answer questions below and note any comments on interview.

5 Were there any problems with the Seven-Day PAR interview?

- ₀ No
₁ Yes

6 Do you think this was a valid Seven-Day PAR interview?

- ₀ No
₁ Yes

7 Were there any activities reported by the participant that you don't know how to classify?

- ₀ No
₁ Yes

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

6-Day Food Record

Complete below OR Not done → Specify reason (use Codelist below): _____

Staff initials: _____
first middle last

			Replacement Values		
Day of DLW	Date of Record	Record Quality (check only one)	Day of DLW	Date of Record	Record Quality (check only one)
1	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing	8	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing
2	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing	9	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing
3	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing	10	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing
4	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing	11	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing
5	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing	12	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing
6	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing	13	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: ____ Participant Number: ____ Participant's Initials: first middle last ____

Clinic Weight

Weight date and time: day ____ / month ____ / year ____ 00:00 to 23:59 ____:____

Staff initials: first middle last ____

OR Not done → Specify reason (use codelist below): ____

Clinic weight (if the two measurements are more than 0.1 kg apart, measure weight a third time):

Weight 1: ____ . ____ kg

Weight 2: ____ . ____ kg

Weight 3: ____ . ____ kg

Weight of gown: ____ . ____ kg

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Seven-Day Physical Activity Recall (PAR)

Today's date: ____/____/____ Day (check only one): Mon Tues Wed Thurs Fri Sat Sun **OR Not done** → Specify reason (use codelist below): _____

1 Were you employed in the last seven days? No → Skip to question 3 Yes

2 If Yes: Which days (check all that apply)?
 Mon Tues Wed Thurs Fri Sat Sun

3 Which days do you consider your weekend, or non-work, days?
 Mon Tues Wed Thurs Fri Sat Sun

Day #	Day of Week	Date ____/____/____ <small>day month year</small>	Sleep Time		Work Time		Morning (in minutes)			Afternoon (in minutes)			Evening (in minutes)		
			In Bed	Up	Start	Stop	Mod.	Hard	Very Hard	Mod.	Hard	Very Hard	Mod.	Hard	Very Hard
7	(yester- day)	____/____/____ <small>day month year</small>	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	_____	_____	_____	_____	_____	_____	_____	_____	_____
6		____/____/____ <small>day month year</small>	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	_____	_____	_____	_____	_____	_____	_____	_____	_____
5		____/____/____ <small>day month year</small>	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	_____	_____	_____	_____	_____	_____	_____	_____	_____
4		____/____/____ <small>day month year</small>	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	_____	_____	_____	_____	_____	_____	_____	_____	_____
3		____/____/____ <small>day month year</small>	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	_____	_____	_____	_____	_____	_____	_____	_____	_____
2		____/____/____ <small>day month year</small>	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	_____	_____	_____	_____	_____	_____	_____	_____	_____
1	(1 week ago)	____/____/____ <small>day month year</small>	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	_____	_____	_____	_____	_____	_____	_____	_____	_____

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Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: ____ Participant Number: ____ Participant's Initials: first middle last ____

Seven-Day Physical Activity Recall (PAR) (continued)

4 Compared to your physical activity over the past three months, was last week's physical activity more, less, or about the same (check only one)?

- ₁ More
₂ Less
₃ About the same

Interviewer: Please answer questions below and note any comments on interview.

5 Were there any problems with the Seven-Day PAR interview?

- ₀ No
₁ Yes

6 Do you think this was a valid Seven-Day PAR interview?

- ₀ No
₁ Yes

7 Were there any activities reported by the participant that you don't know how to classify?

- ₀ No
₁ Yes

Center Number: ____ Participant Number: ____ Participant's Initials: first middle last ____

Handgrip Strength

Date and time of assessment: ____/____/____ 00:00 to 23:59
day month year

Staff initials: first middle last ____

OR Not done → Specify reason (use codelist below): ____

- 1 Dynamometer handle position: _____
- 2 Dominant hand (check only one): ₁ Left ₂ Right ₃ Ambidextrous
- 3 Handgrip strength:

Handgrip Strength	Zero Meter Check	Right Hand	Zero Meter Check	Left Hand
Test 1—peak force	<input type="checkbox"/> ₀	_____ kg	<input type="checkbox"/> ₀	_____ kg
Test 2—peak force	<input type="checkbox"/> ₀	_____ kg	<input type="checkbox"/> ₀	_____ kg
Test 3—peak force	<input type="checkbox"/> ₀	_____ kg	<input type="checkbox"/> ₀	_____ kg

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Isometric/Isokinetic Knee Extension and Flexion

Date and time of assessment: ____/____/____ :____:____
day month year 00:00 to 23:59

Staff initials: _____
first middle last

OR Not done → Specify reason (use codelist below): _____

- 1** Recent injury or pain—right knee? ₀ No ₁ Yes
- 2** Recent injury or pain—left knee? ₀ No ₁ Yes
- 3** Specify machine used (PBRC only): ₀ Cybex ₁ Biolex

All values corrected for gravity effect torque		Right Leg	Left Leg	If Not Done, Specify Reason (Use codelist below)
3 60°/sec knee extension	peak torque	_____ N.m	_____ N.m	_____
	total work	_____ N.m	_____ N.m	
	average power	_____ watts	_____ watts	
4 60°/sec knee flexion	peak torque	_____ N.m	_____ N.m	_____
	total work	_____ N.m	_____ N.m	
	average power	_____ watts	_____ watts	
5 180°/sec knee extension	peak torque	_____ N.m	_____ N.m	_____
	total work	_____ N.m	_____ N.m	
	average power	_____ watts	_____ watts	
	work fatigue index	_____ %	_____ %	
6 180°/sec knee flexion	peak torque	_____ N.m	_____ N.m	_____
	total work	_____ N.m	_____ N.m	
	average power	_____ watts	_____ watts	
	work fatigue index	_____ %	_____ %	
7 Isometric knee extension: trial 1	peak torque	_____ N.m	_____ N.m	_____
	trial 2 peak torque	_____ N.m	_____ N.m	
	trial 3 peak torque	_____ N.m	_____ N.m	
8 Isometric knee flexion: trial 1	peak torque	_____ N.m	_____ N.m	_____
	trial 2 peak torque	_____ N.m	_____ N.m	
	trial 3 peak torque	_____ N.m	_____ N.m	

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Doubly Labeled Water (DLW)

1 Date and time of DLW dosing: _____ / _____ / _____ : _____
day month year 00:00 to 23:59 Staff initials: _____
first middle last

OR Not done → Specify reason (use codelist below): _____

2 DLW dose mixture ID and bottle number: _____ - _____ - _____ - CA

3 Exact weight of DLW mixture: _____ . _____ grams

4 Urine samples:

Collection	Sample	Date and Time Collected
Day 0 (Visit 4)	D0a	_____ / _____ / _____ : _____ <small>day month year 00:00 to 23:59</small>
	D0b	_____ / _____ / _____ : _____ <small>day month year 00:00 to 23:59</small>
Day 7 (Visit 5)	D7a	_____ / _____ / _____ : _____ <small>day month year 00:00 to 23:59</small>
	D7b	_____ / _____ / _____ : _____ <small>day month year 00:00 to 23:59</small>
Day 14 (Visit 7)	D14a	_____ / _____ / _____ : _____ <small>day month year 00:00 to 23:59</small>
	D14b	_____ / _____ / _____ : _____ <small>day month year 00:00 to 23:59</small>

5 Affix CRF page label(s) corresponding to this urine sample set:

Affix
Label
Here

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: ____ Participant Number: ____ Participant's Initials: first middle last

Clinic Weight

Weight date and time: ____/____/____ : ____
day month year 00:00 to 23:59

Staff initials: first middle last

OR Not done → Specify reason (see Codelist below): ____

Clinic weight (if the two measurements are more than 0.1 kg apart, measure weight a third time):

Weight 1: ____ . ____ kg

Weight 2: ____ . ____ kg

Weight 3: ____ . ____ kg

Weight of gown: ____ . ____ kg

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

VO₂ Max

1 Date and time of test: ____/____/____ year ____:____
day month year 00:00 to 23:59 **Staff initials:** ____
first middle last

OR Not done → Specify reason (use codelist below): ____

2 At what time was the participant's last meal/snack eaten? ____:____
00:00 to 23:59

3 Rest ECG: Rhythm (check only one): ₁ Sinus ₂ Atrial fibrillation ₉₈ Other
Ventricular conduction (check only one): ₁ Normal ₂ LBBB ₃ RBBB

4 Heart rate (HR) data: Resting heart rate: _____ bpm
 Age-predicted heart rate: _____ bpm
 Heart rate (max): _____ bpm

5 Reason(s) for termination of testing (check all that apply):

- Symptom limited (dyspnea, fatigue)
- Angina/ischemia → **Complete all that apply:** HR when true cardiac angina occurred: _____ bpm OR ₉₆ NA
 HR when ischemic ECG changes occurred: _____ bpm OR ₉₆ NA
- Serious arrhythmias (VT or SVT)
- Changes in blood pressure
- Ventricular ischemia (schedule stress image study, complete ventricular episode report)
- Orthopedic/extremity complaints (pains/cramps)
- Other (specify): _____

6 Did frequent ventricular ectopy occur (e.g., ≥ 7 PVCs/min, bi/tri-geminy, NSVT [≥ 3 beats])?

- ₀ No
- ₁ Yes → **If Yes: When did it occur (check all that apply)?** During exercise During recovery

7 Peak VO₂: _____ mL/kg/min _____ L/min

8 Did the participant meet at least 2 of the 3 VO₂ max criteria (see box, right)?

- ₀ No
- ₁ Yes → **If Yes: VO₂ max:** _____ mL/kg/min _____ L/min

a Achieve a plateau in VO₂ (change ≤ 150 mL between the final two stages)
 b RER ≥ 1.1
 c HR max ± 5 bpm of age-predicted maximum

9 Exercise time: ____:____
minutes seconds

10 Blood pressure at VO₂ peak/VO₂ max: ____/____ mm Hg
systolic diastolic

11 Borg RPE score at VO₂ peak/VO₂ max: _____ (6-20)

12 Peak RER: _____

13 VE at VO₂ peak/VO₂ max: _____ L/min

14 VE/VO₂ at VO₂ peak/VO₂ max _____ L/min

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: ____ Participant Number: ____ Participant's Initials: first middle last ____

Seven-Day Physical Activity Recall (PAR) (continued)

4 Compared to your physical activity over the past three months, was last week's physical activity more, less, or about the same (check only one)?

- ₁ More
₂ Less
₃ About the same

Interviewer: Please answer questions below and note any comments on interview.

5 Were there any problems with the Seven-Day PAR interview?

- ₀ No
₁ Yes

6 Do you think this was a valid Seven-Day PAR interview?

- ₀ No
₁ Yes

7 Were there any activities reported by the participant that you don't know how to classify?

- ₀ No
₁ Yes

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

6-Day Food Record

Complete below OR Not done → Specify reason (use Codelist below): _____ Staff initials: _____
first middle last

			Replacement Values		
Day of DLW	Date of Record	Record Quality (check only one)	Day of DLW	Date of Record	Record Quality (check only one)
1	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing	8	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing
2	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing	9	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing
3	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing	10	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing
4	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing	11	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing
5	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing	12	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing
6	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing	13	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Delayed-type Hypersensitivity (DTH)

1 Was the DTH worksheet completed?

₀ No

₁ Yes → If Yes: Were any Exclusion criteria met? ₀ No → Proceed with test

₁ Yes → STOP. Do not administer test.

2 Date of injection: _____ / _____ / _____ OR Not done → Specify reason (use codelist below): _____
day month year

3 Injection by (initials): _____
first middle last

4 Arm injected: ₁ Right ₂ Left

5 DTH results:

Note: For each reaction, measure two diameters in millimeters (mm). The first diameter is called the maximum diameter because the induration may not be in the shape of a circle. If the induration is an oval shape, first measure the long diameter and then the diameter perpendicular to it. Do not measure erythema. Reaction is considered positive if the average diameter is equal to or greater than 5 mm.

A = Largest diameter

B = Second diameter perpendicular to A

Antigen	24 Hour (@Visit 7)			48 Hour (@Visit 8)		
	A (diameter)	B (diameter)	Read By:	A (diameter)	B (diameter)	Read By:
1 Normal saline	_____ mm	_____ mm	 <small>first middle last</small> (initials)	_____ mm	_____ mm	 <small>first middle last</small> (initials)
2 Tetanus toxoid (TT)	_____ mm	_____ mm		_____ mm	_____ mm	
3 Candida	_____ mm	_____ mm		_____ mm	_____ mm	
4 Trichophyton	_____ mm	_____ mm		_____ mm	_____ mm	

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Clinic Weight

Weight date and time: _____ / _____ / _____ : _____
day month year 00:00 to 23:59

Staff initials: _____
first middle last

OR Not done → Specify reason (use Codelist below): _____

Clinic weight (if the first two measurements are more than 0.1 kg apart, measure weight a third time):

Weight 1: _____ . _____ kg

Weight 2: _____ . _____ kg

Weight 3: _____ . _____ kg

Weight of gown: _____ . _____ kg

Vital Signs

Assessment date and time: _____ / _____ / _____ : _____
day month year 00:00 to 23:59

If waist measurement not done → Specify reason (use codelist below): _____

1 Natural waist measurement

(if the first two measurements are more than 1.0 cm apart, measure natural waist circumference a third time):

Staff initials: _____
first middle last

Natural waist measurement 1: _____ . _____ cm

Natural waist measurement 2: _____ . _____ cm

Natural waist measurement 3: _____ . _____ cm

2 Umbilical point waist measurement (if the first two measurements are more than 1.0 cm apart, measure umbilical point waist circumference a third time):

Umbilical point waist measurement 1: _____ . _____ cm

Umbilical point waist measurement 2: _____ . _____ cm

Umbilical point waist measurement 3: _____ . _____ cm

3 Pulse: _____ bpm OR Not done → Specify reason (use codelist below): _____

Staff initials: _____
first middle last

4 Temperature: _____ . _____ °C OR Not done → Specify reason (use codelist below): _____

Staff initials: _____
first middle last

5 Respirations: _____ per minute OR Not done → Specify reason (use codelist below): _____

Staff initials: _____
first middle last

6 Blood pressure (check only one): ₁ Left arm ₂ Right arm

Staff initials: _____
first middle last

6a Blood pressure 1: _____ / _____ mm Hg Time: _____ : _____
systolic diastolic 00:00 to 23:59 OR Not done → Specify reason (use codelist below): _____

6b Blood pressure 2: _____ / _____ mm Hg Time: _____ : _____
systolic diastolic 00:00 to 23:59

6c Blood pressure 3: _____ / _____ mm Hg Time: _____ : _____
systolic diastolic 00:00 to 23:59

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Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Pregnancy Test

Complete only for females.

Does participant have reproductive potential?

₀ No

₁ Yes → If Yes: Date urine pregnancy test performed: _____ / _____ / _____
day month year

Results: ₁ Negative

₂ Positive

Core Temperature

Staff Initials	Provide Date of Sample Collection/Procedure	Time of Sample Collection/Procedure	If Not Done, Reason <small>(Use codelist below)</small>
<small>first middle last</small>	Start Date: ____ / ____ / ____ <small>day month year</small>	Start Time ____ : ____ <small>00:00 to 23:59</small>	_____
	Stop Date: ____ / ____ / ____ <small>day month year</small>	Stop Time ____ : ____ <small>00:00 to 23:59</small>	

Inpatient Admission and Discharge

1 Inpatient admission date and time: _____ / _____ / _____ _____ : _____
day month year 00:00 to 23:59

2 Inpatient discharge date and time: _____ / _____ / _____ _____ : _____
day month year 00:00 to 23:59

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: _____ Participant Number: _____ Participant's Initials: _____

Seven-Day Physical Activity Recall (PAR)

Today's date: ____/____/____ Day (check only one): Mon Tues Wed Thurs Fri Sat Sun OR Not done → Specify reason (use code/1st below): _____

1 Were you employed in the last seven days? No → Skip to question 3 Yes

2 If Yes: Which days (check all that apply)? Mon Tues Wed Thurs Fri Sat Sun

3 Which days do you consider your weekend, or non-work, days? Mon Tues Wed Thurs Fri Sat Sun

Interviewer initials: _____

Day #	Day of Week	Date	Sleep Time		Work Time		Morning (in minutes)			Afternoon (in minutes)			Evening (in minutes)						
			In Bed	Up	Start	Stop	Mod.	Hard	Very Hard	Mod.	Hard	Very Hard	Mod.	Hard	Very Hard				
7	(yester- day)	____/____/____ day month year	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59													
6		____/____/____ day month year	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59													
5		____/____/____ day month year	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59													
4		____/____/____ day month year	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59													
3		____/____/____ day month year	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59													
2		____/____/____ day month year	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59													
1	(1 week ago)	____/____/____ day month year	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59													

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: ____ Participant Number: ____ Participant's Initials: first middle last ____

Seven-Day Physical Activity Recall (PAR) (continued)

4 Compared to your physical activity over the past three months, was last week's physical activity more, less, or about the same (check only one)?

- ₁ More
₂ Less
₃ About the same

Interviewer: Please answer questions below and note any comments on interview.

5 Were there any problems with the Seven-Day PAR interview?

- ₀ No
₁ Yes

6 Do you think this was a valid Seven-Day PAR interview?

- ₀ No
₁ Yes

7 Were there any activities reported by the participant that you don't know how to classify?

- ₀ No
₁ Yes

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Outcomes Labs

Date and time of last meal: _____ / _____ / _____ : _____
day month year 00:00 to 23:59

Date and time sample collection started: _____ / _____ / _____ : _____
day month year 00:00 to 23:59

Sample	Sample Complete?	If Not Done, Reason (Use codelist below)	Staff Initials
Catecholamines	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	_____	<small>first middle last</small>
Blood	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	_____	<small>first middle last</small>
Oral glucose tolerance test (OGTT)	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	_____	<small>first middle last</small>

If a sample is not obtained, indicate with a Not Done.

Biopsy Labs

Sample	Date of Collection	If Not Done, Reason (Use codelist below)	Staff Initials
Muscle biopsy	_____ / _____ / _____ <small>day month year</small>	_____	<small>first middle last</small>
Fat biopsy	_____ / _____ / _____ <small>day month year</small>	_____	<small>first middle last</small>

24-hour Urine Collection

Total Volume Collected	Date of Sample Collection	Time of Sample Collection	If Not Done, Reason (Use codelist below)	Staff Initials
_____ mL	Start Date: _____ / _____ / _____ <small>day month year</small> Stop Date: _____ / _____ / _____ <small>day month year</small>	Start Time: _____ : _____ <small>00:00 to 23:59</small> Stop Time: _____ : _____ <small>00:00 to 23:59</small>	_____	<small>first middle last</small>

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Sex Hormone

If Not Done → Specify reason (use codelist below): _____

Contraception method (females only):

None OR Check all that apply:

Oral contraceptive → Specify: _____

Record on Concomitant Medications page

Other → Specify (e.g., barrier, IUD): _____

Day 1	Date	Time	If Not Done, Reason (use codelist)	Staff Initials
Day 1 of menses (females only)				
Date and time of last meal (males only)	____/____/____ <small>day month year</small>	____:____ <small>00:00 to 23:59</small>		
Hormone level blood draw 1 (males only)	____/____/____ <small>day month year</small>	____:____ <small>00:00 to 23:59</small>	_____	_____ <small>first middle last</small>
Hormone level blood draw 2 (females only) <i>Progesterone level</i>				
Day 2	Date	Time	If Not Done, Reason (use codelist)	Staff Initials
Date and time of last meal				
Hormone level blood draw 3 (females only) <i>Progesterone level</i>				

DXA Scan

1 Has the participant taken a calcium supplement today?

₀ No ₁ Yes → If Yes: Proceed with scan and document in the Subject Scan Log to inform the QA Center.

2 Were any studies involving barium or radioisotopes performed within 4 weeks prior to the scheduled DXA exam?

₀ No ₁ Yes

DXA Scan		DXA Rescan OR <input type="checkbox"/> ₉₆ NA
Date of scan: ____/____/____ <small>day month year</small>		Date of rescan: ____/____/____ <small>day month year</small>
Area Scanned Check all that apply	If Not Done, Reason (Use codelist below)	Area Scanned Check all that apply
<input type="checkbox"/> Whole body	_____	<input type="checkbox"/> Whole body

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

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Center Number: ____ Participant Number: ____ Participant's Initials:
first middle last

Metabolic Rate			
Sample	Date of Collection	If Not Done, Reason <i>(Use codelist below)</i>	Staff Initials
Resting Metabolic Rate (RMR)—Visit 7	____/____/____ <small>day month year</small>	_____	_____ <small>first middle last</small>
Cart ID	<input type="checkbox"/> Tufts-003 (623-002) <input type="checkbox"/> WASH U-001 (623-003) <input type="checkbox"/> PBRC-016 (623-005) <input type="checkbox"/> Tufts-006 (623-006) <input type="checkbox"/> WASH U-002 (623-004) <input type="checkbox"/> PBRC-017 (623-001)		
Sample	Date of Collection	If Not Done, Reason <i>(Use codelist below)</i>	Staff Initials
Resting Metabolic Rate (RMR)—Visit 8	____/____/____ <small>day month year</small>	_____	_____ <small>first middle last</small>
Cart ID	<input type="checkbox"/> Tufts-003 (623-002) <input type="checkbox"/> WASH U-001 (623-003) <input type="checkbox"/> PBRC-016 (623-005) <input type="checkbox"/> Tufts-006 (623-006) <input type="checkbox"/> WASH U-002 (623-004) <input type="checkbox"/> PBRC-017 (623-001)		

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: ____ Participant Number: ____ Participant's Initials: first middle last ____

Randomization

Date of randomization: ____ / ____ / ____
day month year

Treatment Group

To which treatment group was the participant assigned (check only one):

- ₁ CR—calorie restricted
₂ AL—ab libitum (control)

Intervention

Did participant start intervention?

- ₀ No → Complete the Study completion/Early Discontinuation of Study Evaluation
₁ Yes → If Yes: Date intervention started: ____ / ____ / ____
day month year

Staff Signature NOTE: Signature of staff that randomized participant

Signature: _____ Date: ____ / ____ / ____
day month year

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Clinic Weight

Weight date and time: _____ / _____ / _____ : _____
day month year 00:00 to 23:59

Staff initials: _____
first middle last

OR Not done → Specify reason (use Codelist below): _____

Clinic weight (if the first two measurements are more than 0.1 kg apart, measure weight a third time):

Weight 1: _____ . _____ kg

Weight 2: _____ . _____ kg

Weight 3: _____ . _____ kg

Weight of gown: _____ . _____ kg

Vital Signs

Assessment date and time: _____ / _____ / _____ : _____
day month year 00:00 to 23:59

If waist measurement not done → Specify reason (use codelist below): _____

1 Natural waist measurement
 (if the first two measurements are more than 1.0 cm apart, measure natural waist circumference a third time):

Staff initials: _____
first middle last

Natural waist measurement 1: _____ . _____ cm

Natural waist measurement 2: _____ . _____ cm

Natural waist measurement 3: _____ . _____ cm

2 Umbilical point waist measurement (if the first two measurements are more than 1.0 cm apart, measure umbilical point waist circumference a third time):

Umbilical point waist measurement 1: _____ . _____ cm

Umbilical point waist measurement 2: _____ . _____ cm

Umbilical point waist measurement 3: _____ . _____ cm

3 Pulse: _____ bpm OR Not done → Specify reason (use codelist below): _____

Staff initials: _____
first middle last

4 Temperature: _____ . _____ °C OR Not done → Specify reason (use codelist below): _____

Staff initials: _____
first middle last

5 Respirations: _____ per minute OR Not done → Specify reason (use codelist below): _____

Staff initials: _____
first middle last

6 Blood pressure (check only one): ₁ Left arm ₂ Right arm

Staff initials: _____
first middle last

6a Blood pressure 1: _____ / _____ mm Hg Time: _____ : _____
systolic diastolic 00:00 to 23:59 OR Not done → Specify reason (use codelist below): _____

6b Blood pressure 2: _____ / _____ mm Hg Time: _____ : _____
systolic diastolic 00:00 to 23:59

6c Blood pressure 3: _____ / _____ mm Hg Time: _____ : _____
systolic diastolic 00:00 to 23:59

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

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Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

12-Lead ECG

Date and Time	Findings	Staff Initials
____ / ____ / ____ : ____ <small>day month year 00:00 to 23:59</small> OR Not done → Specify reason <small>(see codelist below):</small> _____	Is ECG (check only one): <input type="checkbox"/> ₁ Normal <input type="checkbox"/> ₂ Abnormal, not clinically significant (specify): _____ _____ <input type="checkbox"/> ₃ Abnormal, clinically significant (specify): _____ _____	 <small>first middle last</small>

Safety Labs

Date and time of last meal: ____ / ____ / ____ : ____
day month year 00:00 to 23:59
 Date and time of sample collection: ____ / ____ / ____ : ____
day month year 00:00 to 23:59

Sample	Sample Complete?	If Not Done, Reason <small>(Use codelist below)</small>	Staff Initials
Blood	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	_____	<small>first middle last</small>
Urine	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	_____	<small>first middle last</small>

Contraception

If Not Done → Specify reason (use codelist below): _____

Contraception method (females only):	<input type="checkbox"/> None OR Check all that apply: <input type="checkbox"/> Oral contraceptive → Specify: _____ <small>Record on Concomitant Medications page</small> <input type="checkbox"/> Other → Specify (e.g., barrier, IUD): _____
--------------------------------------	--

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: ____ Participant Number: ____ Participant's Initials: first middle last ____

Date completed: ____/____/____ OR Not done → Specify reason (use codelist below): ____
day month year

BDI-II

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully and then pick out the one statement in each group that best describes the way you have been feeling during the past two weeks, including today. Check the box beside the statement you have picked. Be sure that you check only one statement for each group, including item 16 and item 18.

- 1 Sadness:**
 - ₀ I do not feel sad
 - ₁ I feel sad much of the time
 - ₂ I am sad all of the time
 - ₃ I am so sad or unhappy that I can't stand it

- 2 Pessimism:**
 - ₀ I am not discouraged about my future
 - ₁ I feel more discouraged about my future than I used to be
 - ₂ I do not expect things to work out for me
 - ₃ I feel my future is hopeless and will only get worse

- 3 Past failure:**
 - ₀ I do not feel like a failure
 - ₁ I have failed more than I should have
 - ₂ As I look back, I see a lot of failures
 - ₃ I feel I am a total failure as a person

- 4 Loss of pleasure:**
 - ₀ I get as much pleasure as I ever did from the things I enjoy
 - ₁ I don't enjoy things as much as I used to
 - ₂ I get very little pleasure from the things I used to enjoy
 - ₃ I can't get any pleasure from the things I used to enjoy

- 5 Guilty feelings:**
 - ₀ I don't feel particularly guilty
 - ₁ I feel guilty over many things I have done or should have done
 - ₂ I feel quite guilty most of the time
 - ₃ I feel guilty all of the time

- 6 Punishment feelings:**
 - ₀ I don't feel I am being punished
 - ₁ I feel I may be punished
 - ₂ I expect to be punished
 - ₃ I feel I am being punished

- 7 Self-dislike:**
 - ₀ I feel the same about myself as ever
 - ₁ I have lost confidence in myself
 - ₂ I am disappointed in myself
 - ₃ I dislike myself

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Participant's Initials: first middle last ____

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Center Number: ____ Participant Number: ____ Participant's Initials:
first middle last

BDI-II (continued)

- 8 Self-criticalness:**
- ₀ I don't criticize or blame myself more than usual
 - ₁ I am more critical of myself than I used to be
 - ₂ I criticize myself for all of my faults
 - ₃ I blame myself for everything bad that happens
- 9 Suicidal thoughts or wishes:**
- ₀ I don't have any thoughts of killing myself
 - ₁ I have thoughts of killing myself but I would not carry them out
 - ₂ I would like to kill myself
 - ₃ I would kill myself if I had the chance
- 10 Crying:**
- ₀ I don't cry any more than I used to
 - ₁ I cry more than I used to
 - ₂ I cry over every little thing
 - ₃ I feel like crying, but I can't
- 11 Agitation:**
- ₀ I am no more wound up or restless than usual
 - ₁ I feel more restless or wound up than usual
 - ₂ I am so restless or agitated that it's hard to stay still
 - ₃ I am so restless or agitated that I have to keep moving or doing something
- 12 Loss of interest:**
- ₀ I have not lost interest in other people or activities
 - ₁ I am less interested in other people or things than before
 - ₂ I have lost most of my interest in other people or things
 - ₃ It's hard to get interested in anything
- 13 Indecisiveness:**
- ₀ I make decisions about as well as ever
 - ₁ I find it more difficult to make decisions than usual
 - ₂ I have much greater difficulty in making decisions than I used to
 - ₃ I have trouble making my decisions
- 14 Worthlessness:**
- ₀ I do not feel I am worthless
 - ₁ I don't consider myself as worthwhile and useful as I used to
 - ₂ I feel more worthless as compared to other people
 - ₃ I feel utterly worthless
- 15 Loss of energy:**
- ₀ I have as much energy as ever
 - ₁ I have less energy than I used to have
 - ₂ I don't have enough energy to do very much
 - ₃ I don't have enough energy to do anything

Participant's Initials:
first middle last

Center Number: ____ Participant Number: ____ Participant's Initials:
first middle last

BDI-II (continued)

- 16 Changes in sleeping pattern:**
- ₀ I have not experienced any change in my sleeping pattern
 - ₁ I sleep somewhat more than usual
 - ₂ I sleep somewhat less than usual
 - ₃ I sleep a lot more than usual
 - ₄ I sleep a lot less than usual
 - ₅ I sleep most of the day
 - ₆ I wake up 1-2 hours early and can't get back to sleep

- 17 Irritability:**
- ₀ I am no more irritable than usual
 - ₁ I am more irritable than usual
 - ₂ I am much more irritable than usual
 - ₃ I am irritable all of the time

- 18 Changes in appetite:**
- ₀ I have not experienced any change in my appetite
 - ₁ My appetite is somewhat less than usual
 - ₂ My appetite is somewhat greater than usual
 - ₃ My appetite is much less than before
 - ₄ My appetite is much greater than usual
 - ₅ I have no appetite at all
 - ₆ I crave food all of the time

- 19 Concentration difficulty:**
- ₀ I can concentrate as well as ever
 - ₁ I can't concentrate as well as usual
 - ₂ It's hard to keep my mind on anything for very long
 - ₃ I find I can't concentrate on anything

- 20 Tiredness or fatigue:**
- ₀ I am no more tired or fatigued than usual
 - ₁ I get more tired or fatigued more easily than usual
 - ₂ I am too tired or fatigued to do a lot of the things I used to do
 - ₃ I am too tired or fatigued to do most of the things I used to do

- 21 Loss of interest in sex:**
- ₀ I have not noticed any recent change in my interest in sex
 - ₁ I am less interested in sex than I used to be
 - ₂ I am much less interested in sex now
 - ₃ I have lost interest in sex completely

Participant's Initials:
first middle last

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Clinic Weight

Weight date and time: _____ / _____ / _____ : _____
day month year 00:00 to 23:59

Staff initials: _____
first middle last

OR Not done → Specify reason (use Codelist below): _____

Clinic weight (if the first two measurements are more than 0.1 kg apart, measure weight a third time):

Weight 1: _____ . _____ kg

Weight 2: _____ . _____ kg

Weight 3: _____ . _____ kg

Weight of gown: _____ . _____ kg

Vital Signs

Assessment date and time: _____ / _____ / _____ : _____
day month year 00:00 to 23:59

If waist measurement not done → Specify reason (use codelist below): _____

1 Natural waist measurement

(if the first two measurements are more than 1.0 cm apart, measure natural waist circumference a third time):

Staff initials: _____
first middle last

Natural waist measurement 1: _____ . _____ cm

Natural waist measurement 2: _____ . _____ cm

Natural waist measurement 3: _____ . _____ cm

2 Umbilical point waist measurement (if the first two measurements are more than 1.0 cm apart, measure umbilical point waist circumference a third time):

Umbilical point waist measurement 1: _____ . _____ cm

Umbilical point waist measurement 2: _____ . _____ cm

Umbilical point waist measurement 3: _____ . _____ cm

3 Pulse: _____ bpm OR Not done → Specify reason (use codelist below): _____

Staff initials: _____
first middle last

4 Temperature: _____ . _____ °C OR Not done → Specify reason (use codelist below): _____

Staff initials: _____
first middle last

5 Respirations: _____ per minute OR Not done → Specify reason (use codelist below): _____

Staff initials: _____
first middle last

6 Blood pressure (check only one): ₁ Left arm ₂ Right arm

Staff initials: _____
first middle last

6a Blood pressure 1: _____ / _____ mm Hg Time: _____ : _____
systolic diastolic 00:00 to 23:59 OR Not done →
 Specify reason (use codelist below): _____

6b Blood pressure 2: _____ / _____ mm Hg Time: _____ : _____
systolic diastolic 00:00 to 23:59

6c Blood pressure 3: _____ / _____ mm Hg Time: _____ : _____
systolic diastolic 00:00 to 23:59

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

12-Lead ECG

Date and Time	Findings	Staff Initials
____ / ____ / ____ : ____ <small>day month year 00:00 to 23:59</small> OR Not done → Specify reason <small>(see codelist below):</small> _____	Is ECG (check only one): <input type="checkbox"/> ₁ Normal <input type="checkbox"/> ₂ Abnormal, not clinically significant (specify): _____ _____ <input type="checkbox"/> ₃ Abnormal, clinically significant (specify): _____ _____	_____ <small>first middle last</small>

Safety Labs

Date and time of last meal: ____ / ____ / ____ : ____
day month year 00:00 to 23:59
 Date and time of sample collection: ____ / ____ / ____ : ____
day month year 00:00 to 23:59

Sample	Sample Complete?	If Not Done, Reason <small>(Use codelist below)</small>	Staff Initials
Blood	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	_____	_____ <small>first middle last</small>
Urine	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	_____	_____ <small>first middle last</small>

Outcomes Labs

Date and time of last meal: ____ / ____ / ____ : ____
day month year 00:00 to 23:59
 Date and time sample collection started: ____ / ____ / ____ : ____
day month year 00:00 to 23:59

Sample	Sample Complete?	If Not Done, Reason <small>(Use codelist below)</small>	Staff Initials
Blood	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	_____	_____ <small>first middle last</small>

If a sample is not obtained, indicate with a Not Done.

Contraception

If Not Done → Specify reason (use codelist below): _____

Contraception method (females only):	<input type="checkbox"/> None OR Check all that apply: <input type="checkbox"/> Oral contraceptive → Specify: _____ <small>Record on Concomitant Medications page</small> <input type="checkbox"/> Other → Specify (e.g., barrier, IUD): _____
--------------------------------------	--

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: ____ Participant Number: ____ Participant's Initials: first middle last ____

Date completed: ____/____/____ OR Not done → Specify reason (use codelist below): ____
day month year

BDI-II

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully and then pick out the one statement in each group that best describes the way you have been feeling during the past two weeks, including today. Check the box beside the statement you have picked. Be sure that you check only one statement for each group, including item 16 and item 18.

- 1 Sadness:**

 - ₀ I do not feel sad
 - ₁ I feel sad much of the time
 - ₂ I am sad all of the time
 - ₃ I am so sad or unhappy that I can't stand it

- 2 Pessimism:**

 - ₀ I am not discouraged about my future
 - ₁ I feel more discouraged about my future than I used to be
 - ₂ I do not expect things to work out for me
 - ₃ I feel my future is hopeless and will only get worse

- 3 Past failure:**

 - ₀ I do not feel like a failure
 - ₁ I have failed more than I should have
 - ₂ As I look back, I see a lot of failures
 - ₃ I feel I am a total failure as a person

- 4 Loss of pleasure:**

 - ₀ I get as much pleasure as I ever did from the things I enjoy
 - ₁ I don't enjoy things as much as I used to
 - ₂ I get very little pleasure from the things I used to enjoy
 - ₃ I can't get any pleasure from the things I used to enjoy

- 5 Guilty feelings:**

 - ₀ I don't feel particularly guilty
 - ₁ I feel guilty over many things I have done or should have done
 - ₂ I feel quite guilty most of the time
 - ₃ I feel guilty all of the time

- 6 Punishment feelings:**

 - ₀ I don't feel I am being punished
 - ₁ I feel I may be punished
 - ₂ I expect to be punished
 - ₃ I feel I am being punished

- 7 Self-dislike:**

 - ₀ I feel the same about myself as ever
 - ₁ I have lost confidence in myself
 - ₂ I am disappointed in myself
 - ₃ I dislike myself

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Participant's Initials: first middle last ____

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Center Number: ____ Participant Number: ____ Participant's Initials:
first middle last

BDI-II (continued)

- 8 Self-criticalness:**
- ₀ I don't criticize or blame myself more than usual
 - ₁ I am more critical of myself than I used to be
 - ₂ I criticize myself for all of my faults
 - ₃ I blame myself for everything bad that happens
- 9 Suicidal thoughts or wishes:**
- ₀ I don't have any thoughts of killing myself
 - ₁ I have thoughts of killing myself but I would not carry them out
 - ₂ I would like to kill myself
 - ₃ I would kill myself if I had the chance
- 10 Crying:**
- ₀ I don't cry any more than I used to
 - ₁ I cry more than I used to
 - ₂ I cry over every little thing
 - ₃ I feel like crying, but I can't
- 11 Agitation:**
- ₀ I am no more wound up or restless than usual
 - ₁ I feel more restless or wound up than usual
 - ₂ I am so restless or agitated that it's hard to stay still
 - ₃ I am so restless or agitated that I have to keep moving or doing something
- 12 Loss of interest:**
- ₀ I have not lost interest in other people or activities
 - ₁ I am less interested in other people or things than before
 - ₂ I have lost most of my interest in other people or things
 - ₃ It's hard to get interested in anything
- 13 Indecisiveness:**
- ₀ I make decisions about as well as ever
 - ₁ I find it more difficult to make decisions than usual
 - ₂ I have much greater difficulty in making decisions than I used to
 - ₃ I have trouble making my decisions
- 14 Worthlessness:**
- ₀ I do not feel I am worthless
 - ₁ I don't consider myself as worthwhile and useful as I used to
 - ₂ I feel more worthless as compared to other people
 - ₃ I feel utterly worthless
- 15 Loss of energy:**
- ₀ I have as much energy as ever
 - ₁ I have less energy than I used to have
 - ₂ I don't have enough energy to do very much
 - ₃ I don't have enough energy to do anything

Participant's Initials:
first middle last

Center Number: ____ Participant Number: ____ Participant's Initials:
first middle last

BDI-II (continued)

- 16 Changes in sleeping pattern:**
- ₀ I have not experienced any change in my sleeping pattern
 - ₁ I sleep somewhat more than usual
 - ₂ I sleep somewhat less than usual
 - ₃ I sleep a lot more than usual
 - ₄ I sleep a lot less than usual
 - ₅ I sleep most of the day
 - ₆ I wake up 1-2 hours early and can't get back to sleep

- 17 Irritability:**
- ₀ I am no more irritable than usual
 - ₁ I am more irritable than usual
 - ₂ I am much more irritable than usual
 - ₃ I am irritable all of the time

- 18 Changes in appetite:**
- ₀ I have not experienced any change in my appetite
 - ₁ My appetite is somewhat less than usual
 - ₂ My appetite is somewhat greater than usual
 - ₃ My appetite is much less than before
 - ₄ My appetite is much greater than usual
 - ₅ I have no appetite at all
 - ₆ I crave food all of the time

- 19 Concentration difficulty:**
- ₀ I can concentrate as well as ever
 - ₁ I can't concentrate as well as usual
 - ₂ It's hard to keep my mind on anything for very long
 - ₃ I find I can't concentrate on anything

- 20 Tiredness or fatigue:**
- ₀ I am no more tired or fatigued than usual
 - ₁ I get more tired or fatigued more easily than usual
 - ₂ I am too tired or fatigued to do a lot of the things I used to do
 - ₃ I am too tired or fatigued to do most of the things I used to do

- 21 Loss of interest in sex:**
- ₀ I have not noticed any recent change in my interest in sex
 - ₁ I am less interested in sex than I used to be
 - ₂ I am much less interested in sex now
 - ₃ I have lost interest in sex completely

Participant's Initials:
first middle last

Center Number: ____ Participant Number: _____ Participant's Initials: ____
first middle last

Date completed: ____/____/____ OR Not done → Specify reason (use codelist below): ____
day month year

Multiaxial Assessment of Eating Disorder Symptoms (MAEDS)

Instructions: Using the scale shown, please rate the following items on a scale from 1 to 7. Please answer as truthfully as possible.

	Never	Very Rarely	Rarely	Sometimes	Often	Very Often	Always
1 Fasting is a good way to lose weight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
2 My sleep isn't as good as it used to be.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
3 I avoid eating for as long as I can.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
4 Certain foods are "forbidden" for me to eat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
5 I can't keep certain foods in my house because I will binge on them.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
6 I can easily make myself vomit.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
7 I can feel that being fat is terrible.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
8 I avoid greasy foods.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
9 It's okay to binge and purge once in a while.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
10 I don't eat certain foods.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
11 I think I am a good person.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
12 My eating is normal.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
13 I can't seem to concentrate lately.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
14 I try to diet by fasting.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
15 I vomit to control my weight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
16 Lately nothing seems enjoyable anymore.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
17 Laxatives help keep you slim.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
18 I don't eat red meat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
19 I eat so rapidly I can't even taste my food.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Participant's Initials: ____
first middle last

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Center Number: ____ Participant Number: ____ Participant's Initials: first middle last _____

Multiaxial Assessment of Eating Disorder Symptoms (MAEDS) (continued)

	Never	Very Rarely	Rarely	Sometimes	Often	Very Often	Always
20 I do everything I can to avoid being overweight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
21 When I feel bloated, I must do something to rid myself of that feeling.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
22 I overeat too frequently.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
23 It's okay to be overweight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
24 Recently I have felt that I am a worthless person.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
25 I would be very upset if I gained 2 pounds.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
26 I crave sweets and carbohydrates.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
27 I lose control when I eat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
28 Being fat would be terrible.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
29 I have thought seriously about suicide lately.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
30 I don't have any energy anymore.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
31 I eat small portions to control my weight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
32 I eat 3 meals a day.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
33 Lately I have been easily irritated.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
34 Some foods should be totally avoided.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
35 I use laxatives to control my weight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
36 I am terrified by the thought of being overweight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
37 Purging is a good way to lose weight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
38 I avoid fatty foods.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇

Participant's Initials: first middle last _____

Center Number: ____ Participant Number: ____ Participant's Initials: _____
first middle last

Multiaxial Assessment of Eating Disorder Symptoms (MAEDS) (continued)

	Never	Very Rarely	Rarely	Sometimes	Often	Very Often	Always
39 Recently I have felt pretty blue.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
40 I am obsessed with becoming overweight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
41 I don't eat fried foods.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
42 I skip meals.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
43 Fat people are unhappy.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
44 People are too concerned with the way I eat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
45 I feel good when I skip meals.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
46 I avoid foods with sugar.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
47 I hate it when I feel fat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
48 I am too fat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
49 I eat until I am completely stuffed.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
50 I hate to eat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
51 I feel guilty about a lot of things these days.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
52 I'm very careful of what I eat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
53 I can "hold off" and not eat even if I am hungry.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
54 I eat even when I am not hungry.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
55 Fat people are disgusting.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
56 I wouldn't mind gaining a few pounds.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇

Participant's Initials: _____
first middle last

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Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Clinic Weight

Weight date and time: ____/____/____ 00:00 to 23:59
day month year

Staff initials: _____
first middle last

OR Not done → Specify reason (use Codelist below): _____

Clinic weight (if the first two measurements are more than 0.1 kg apart, measure weight a third time):

Weight 1: _____ kg

Weight 2: _____ kg

Weight 3: _____ kg

Weight of gown: _____ kg

Vital Signs

Assessment date and time: ____/____/____ 00:00 to 23:59
day month year

If waist measurement not done → Specify reason (use codelist below): _____

1 Natural waist measurement
 (if the first two measurements are more than 1.0 cm apart, measure natural waist circumference a third time):

Staff initials: _____
first middle last

Natural waist measurement 1: _____ cm

Natural waist measurement 2: _____ cm

Natural waist measurement 3: _____ cm

2 Umbilical point waist measurement (if the first two measurements are more than 1.0 cm apart, measure umbilical point waist circumference a third time):

Umbilical point waist measurement 1: _____ cm

Umbilical point waist measurement 2: _____ cm

Umbilical point waist measurement 3: _____ cm

3 Pulse: _____ bpm OR Not done → Specify reason (use codelist below): _____

Staff initials: _____
first middle last

4 Temperature: _____ °C OR Not done → Specify reason (use codelist below): _____

Staff initials: _____
first middle last

5 Respirations: _____ per minute OR Not done → Specify reason (use codelist below): _____

Staff initials: _____
first middle last

6 Blood pressure (check only one): ₁ Left arm ₂ Right arm

Staff initials: _____
first middle last

6a Blood pressure 1: _____/_____ mm Hg Time: _____:_____
systolic diastolic 00:00 to 23:59 OR Not done → Specify reason (use codelist below): _____

6b Blood pressure 2: _____/_____ mm Hg Time: _____:_____
systolic diastolic 00:00 to 23:59

6c Blood pressure 3: _____/_____ mm Hg Time: _____:_____
systolic diastolic 00:00 to 23:59

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Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

12-Lead ECG

Date and Time	Findings	Staff Initials
____ / ____ / ____ : ____ <small>day month year 00:00 to 23:59</small> OR Not done → Specify reason <small>(see codelist below):</small> _____	Is ECG (check only one): <input type="checkbox"/> ₁ Normal <input type="checkbox"/> ₂ Abnormal, not clinically significant (specify): _____ _____ <input type="checkbox"/> ₃ Abnormal, clinically significant (specify): _____ _____	_____ <small>first middle last</small>

Safety Labs

Date and time of last meal: ____ / ____ / ____ : ____
day month year 00:00 to 23:59

Date and time of sample collection: ____ / ____ / ____ : ____
day month year 00:00 to 23:59

Sample	Sample Complete?	If Not Done, Reason <small>(Use codelist below)</small>	Staff Initials
Blood	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	_____	_____ <small>first middle last</small>
Urine	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	_____	_____ <small>first middle last</small>

Contraception

If Not Done → Specify reason (use codelist below): _____

Contraception method (females only):

- None **OR Check all that apply:**
- Oral contraceptive → Specify: _____
Record on Concomitant Medications page
- Other → Specify (e.g., barrier, IUD): _____

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Clinic Weight

Weight date and time: ____/____/____ : ____
day month year 00:00 to 23:59

Staff initials: _____
first middle last

OR Not done → Specify reason (use codelist below): _____

Clinic weight (if the two measurements are more than 0.1 kg apart, measure weight a third time):

Weight 1: _____ . ____ kg

Weight 2: _____ . ____ kg

Weight 3: _____ . ____ kg

Weight of gown: _____ . ____ kg

Pregnancy Test

Complete only for females.

Does participant have reproductive potential?

No

Yes → If Yes: Date urine pregnancy test performed: ____/____/____
day month year

Results: Negative

Positive

DXA Scan

1 Has the participant taken a calcium supplement today?

No

Yes

→ If Yes: Proceed with scan and document in the Subject Scan Log to inform the QA Center.

2 Were any studies involving barium or radioisotopes performed within 4 weeks prior to the scheduled DXA exam?

No

Yes

DXA Scan		DXA Rescan OR <input type="checkbox"/> ₉₆ NA
Date of scan: ____/____/____ <small>day month year</small>		Date of rescan: ____/____/____ <small>day month year</small>
Area Scanned Check all that apply	If Not Done, Reason (Use codelist below)	Area Scanned Check all that apply
<input type="checkbox"/> Whole body	_____	<input type="checkbox"/> Whole body
<input type="checkbox"/> Forearm	_____	<input type="checkbox"/> Forearm
<input type="checkbox"/> Spine	_____	<input type="checkbox"/> Spine
<input type="checkbox"/> Hip	_____	<input type="checkbox"/> Hip

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Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Doubly Labeled Water (DLW)

1 Date and time of DLW dosing: _____ / _____ / _____ : _____
day month year 00:00 to 23:59 Staff initials: _____
first middle last

OR Not done → Specify reason (use codelist below): _____

2 DLW dose mixture ID and bottle number: _____ - _____ - _____ - CA

3 Exact weight of DLW mixture: _____ . _____ grams

4 Urine samples:

Collection	Sample	Date and Time Collected
Pre dosing (PD)	PDa	_____ / _____ / _____ : _____ <small>day month year 00:00 to 23:59</small>
	PDb	_____ / _____ / _____ : _____ <small>day month year 00:00 to 23:59</small>
Day 0 (Visit 2)	D0a	_____ / _____ / _____ : _____ <small>day month year 00:00 to 23:59</small>
	D0b	_____ / _____ / _____ : _____ <small>day month year 00:00 to 23:59</small>
Day 7 (Visit 3)	D7a	_____ / _____ / _____ : _____ <small>day month year 00:00 to 23:59</small>
	D7b	_____ / _____ / _____ : _____ <small>day month year 00:00 to 23:59</small>
Day 14 (Visit 5)	D14a	_____ / _____ / _____ : _____ <small>day month year 00:00 to 23:59</small>
	D14b	_____ / _____ / _____ : _____ <small>day month year 00:00 to 23:59</small>

5 Affix CRF page label(s) corresponding to this urine sample set:

**Affix
Test Sample
Label Here**

**Affix
Retest Sample
Label Here**

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Date completed: ____/____/____ OR Not done → Specify reason (use codelist below): _____
day month year

RAND SF-36

Instructions: This survey asks for your views about your health. This information will help keep track of how well you are able to do your usual activities. Please answer every question by placing a check "X" in the appropriate box. If you are unsure about how to answer a question, give the best answer you can.

1 In general, would you say your health is: ₁ Excellent ₂ Very good ₃ Good ₄ Fair ₅ Poor

2 Compared to one year ago, how would you rate your health in general now? ₁ Much better now than 1 year ago
₂ Somewhat better now than 1 year ago
₃ About the same
₄ Somewhat worse now than 1 year ago
₅ Much worse now than 1 year ago

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes, Limited A Lot	Yes, Limited A Little	No, Not Limited At All
--	--------------------	-----------------------	------------------------

3 Vigorous activities , such as running, lifting heavy objects, participating in strenuous sports	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
---	---------------------------------------	---------------------------------------	---------------------------------------

4 Moderate activities , such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
--	---------------------------------------	---------------------------------------	---------------------------------------

5 Lifting or carrying groceries	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
--	---------------------------------------	---------------------------------------	---------------------------------------

6 Climbing several flights of stairs	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
--	---------------------------------------	---------------------------------------	---------------------------------------

7 Climbing one flight of stairs	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
---	---------------------------------------	---------------------------------------	---------------------------------------

8 Bending, kneeling or stooping	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
--	---------------------------------------	---------------------------------------	---------------------------------------

9 Walking more than a mile	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
--	---------------------------------------	---------------------------------------	---------------------------------------

10 Walking several blocks	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
---	---------------------------------------	---------------------------------------	---------------------------------------

11 Walking one block	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
------------------------------------	---------------------------------------	---------------------------------------	---------------------------------------

12 Bathing or dressing yourself	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
--	---------------------------------------	---------------------------------------	---------------------------------------

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Participant's Initials: _____
first middle last

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Center Number: ____ Participant Number: ____ Participant's Initials: _____
first middle last

Rand SF-36 (continued)

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

Yes **No**

13 Cut down on the **amount of time** you spent on work or other activities ₁ ₂

14 **Accomplished less** than you would like ₁ ₂

15 Were limited in the **kind** of work or other activities ₁ ₂

16 Had **difficulty** performing the work or other activities
(for example, it took extra effort) ₁ ₂

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)

Yes **No**

17 Cut down on the **amount of time** you spent on work or other activities ₁ ₂

18 **Accomplished less** than you would like ₁ ₂

19 Didn't do work or other activities as **carefully** as usual ₁ ₂

20 During the **past 4 weeks**, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors or groups?

- ₁ Not at all
- ₂ Slightly
- ₃ Moderately
- ₄ Quite a bit
- ₅ Extremely

21 How much **bodily** pain have you had during the **past 4 weeks**?

- ₁ None
- ₂ Very mild
- ₃ Mild
- ₄ Moderately
- ₅ Severe
- ₆ Very severe

22 During the **past 4 weeks**, how much did pain interfere with your normal work (including both work outside the home and housework)?

- ₁ Not at all
- ₂ A little bit
- ₃ Moderately
- ₄ Quite a bit
- ₅ Extremely

Participant's Initials: _____
first middle last

Center Number: ____ Participant Number: ____ Participant's Initials:
first middle last

RAND SF-36 (continued)

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks...	All of the Time	Most of the Time	A Good Bit of the Time	Some of the Time	A Little of the Time	None of the Time
23 Did you feel full of pep?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
24 Have you been a very nervous person?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
25 Have you felt so down in the dumps that nothing could cheer you up?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
26 Have you felt calm and peaceful?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
27 Did you have a lot of energy?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
28 Have you felt downhearted and blue?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
29 Did you feel worn out?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
30 Have you been a happy person?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
31 Did you feel tired?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
32 During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc)?						
	All of the Time	Most of the Time	Some of the Time	A Little of the Time	None of the Time	
	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	
How true or false is each of the following statements for you?	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False	
33 I seem to get sick a little easier than other people.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	
34 I am healthy as anybody I know.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	
35 I expect my health to get worse.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	
36 My health is excellent.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	

Participant's Initials:
first middle last

Center Number: ____ Participant Number: ____ Participant's Initials: first middle last ____

Date completed: ____/____/____ OR Not done → Specify reason (use codelist below): ____
day month year

BDI-II

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully and then pick out the one statement in each group that best describes the way you have been feeling during the past two weeks, including today. Check the box beside the statement you have picked. Be sure that you check only one statement for each group, including item 16 and item 18.

- 1 Sadness:** ₀ I do not feel sad
₁ I feel sad much of the time
₂ I am sad all of the time
₃ I am so sad or unhappy that I can't stand it
- 2 Pessimism:** ₀ I am not discouraged about my future
₁ I feel more discouraged about my future than I used to be
₂ I do not expect things to work out for me
₃ I feel my future is hopeless and will only get worse
- 3 Past failure:** ₀ I do not feel like a failure
₁ I have failed more than I should have
₂ As I look back, I see a lot of failures
₃ I feel I am a total failure as a person
- 4 Loss of pleasure:** ₀ I get as much pleasure as I ever did from the things I enjoy
₁ I don't enjoy things as much as I used to
₂ I get very little pleasure from the things I used to enjoy
₃ I can't get any pleasure from the things I used to enjoy
- 5 Guilty feelings:** ₀ I don't feel particularly guilty
₁ I feel guilty over many things I have done or should have done
₂ I feel quite guilty most of the time
₃ I feel guilty all of the time
- 6 Punishment feelings:** ₀ I don't feel I am being punished
₁ I feel I may be punished
₂ I expect to be punished
₃ I feel I am being punished
- 7 Self-dislike:** ₀ I feel the same about myself as ever
₁ I have lost confidence in myself
₂ I am disappointed in myself
₃ I dislike myself

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Participant's Initials: first middle last ____

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Center Number: ____ Participant Number: ____ Participant's Initials:
first middle last

BDI-II (continued)

- 8 Self-criticalness:**
- ₀ I don't criticize or blame myself more than usual
 - ₁ I am more critical of myself than I used to be
 - ₂ I criticize myself for all of my faults
 - ₃ I blame myself for everything bad that happens
- 9 Suicidal thoughts or wishes:**
- ₀ I don't have any thoughts of killing myself
 - ₁ I have thoughts of killing myself but I would not carry them out
 - ₂ I would like to kill myself
 - ₃ I would kill myself if I had the chance
- 10 Crying:**
- ₀ I don't cry any more than I used to
 - ₁ I cry more than I used to
 - ₂ I cry over every little thing
 - ₃ I feel like crying, but I can't
- 11 Agitation:**
- ₀ I am no more wound up or restless than usual
 - ₁ I feel more restless or wound up than usual
 - ₂ I am so restless or agitated that it's hard to stay still
 - ₃ I am so restless or agitated that I have to keep moving or doing something
- 12 Loss of interest:**
- ₀ I have not lost interest in other people or activities
 - ₁ I am less interested in other people or things than before
 - ₂ I have lost most of my interest in other people or things
 - ₃ It's hard to get interested in anything
- 13 Indecisiveness:**
- ₀ I make decisions about as well as ever
 - ₁ I find it more difficult to make decisions than usual
 - ₂ I have much greater difficulty in making decisions than I used to
 - ₃ I have trouble making my decisions
- 14 Worthlessness:**
- ₀ I do not feel I am worthless
 - ₁ I don't consider myself as worthwhile and useful as I used to
 - ₂ I feel more worthless as compared to other people
 - ₃ I feel utterly worthless
- 15 Loss of energy:**
- ₀ I have as much energy as ever
 - ₁ I have less energy than I used to have
 - ₂ I don't have enough energy to do very much
 - ₃ I don't have enough energy to do anything

Participant's Initials:
first middle last

Center Number: ____ Participant Number: ____ Participant's Initials: first middle last ____

BDI-II (continued)

- 16 Changes in sleeping pattern:**
- ₀ I have not experienced any change in my sleeping pattern
 - ₁ I sleep somewhat more than usual
 - ₂ I sleep somewhat less than usual
 - ₃ I sleep a lot more than usual
 - ₄ I sleep a lot less than usual
 - ₅ I sleep most of the day
 - ₆ I wake up 1-2 hours early and can't get back to sleep
- 17 Irritability:**
- ₀ I am no more irritable than usual
 - ₁ I am more irritable than usual
 - ₂ I am much more irritable than usual
 - ₃ I am irritable all of the time
- 18 Changes in appetite:**
- ₀ I have not experienced any change in my appetite
 - ₁ My appetite is somewhat less than usual
 - ₂ My appetite is somewhat greater than usual
 - ₃ My appetite is much less than before
 - ₄ My appetite is much greater than usual
 - ₅ I have no appetite at all
 - ₆ I crave food all of the time
- 19 Concentration difficulty:**
- ₀ I can concentrate as well as ever
 - ₁ I can't concentrate as well as usual
 - ₂ It's hard to keep my mind on anything for very long
 - ₃ I find I can't concentrate on anything
- 20 Tiredness or fatigue:**
- ₀ I am no more tired or fatigued than usual
 - ₁ I get more tired or fatigued more easily than usual
 - ₂ I am too tired or fatigued to do a lot of the things I used to do
 - ₃ I am too tired or fatigued to do most of the things I used to do
- 21 Loss of interest in sex:**
- ₀ I have not noticed any recent change in my interest in sex
 - ₁ I am less interested in sex than I used to be
 - ₂ I am much less interested in sex now
 - ₃ I have lost interest in sex completely

Participant's Initials: first middle last ____

Center Number: ____ Participant Number: _____ Participant's Initials:
first middle last

Date completed: ____/____/____ OR Not done → Specify reason (use codelist below): _____
day month year

Profile of Mood States

Instructions: Please describe **how you feel right now** by checking one box for each of the words listed below.

Feeling	Not At All	A Little	Moderately	Quite A Bit	Extremely
1 Friendly	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
2 Tense	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
3 Angry	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
4 Worn out	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
5 Unhappy	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
6 Clear-headed	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
7 Lively	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
8 Confused	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
9 Sorry for things done	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
10 Shaky	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
11 Listless	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
12 Peeved	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
13 Considerate	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
14 Sad	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
15 Active	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
16 On edge	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
17 Grouchy	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
18 Blue	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
19 Energetic	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
20 Panicky	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

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Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Participant's Initials:
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Center Number: ____ Participant Number: ____ Participant's Initials: _____
first middle last

Profile of Mood States (continued)

Feeling	Not At All	A Little	Moderately	Quite A Bit	Extremely
21 Hopeless	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
22 Relaxed	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
23 Unworthy	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
24 Spiteful	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
25 Sympathetic	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
26 Uneasy	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
27 Restless	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
28 Unable to concentrate	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
29 Fatigued	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
30 Helpful	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
31 Annoyed	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
32 Discouraged	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
33 Resentful	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
34 Nervous	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
35 Lonely	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
36 Miserable	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
37 Muddled	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
38 Cheerful	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
39 Bitter	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
40 Exhausted	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
41 Anxious	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
42 Ready to fight	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
43 Good-natured	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

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Profile of Mood States (continued)

Feeling	Not At All	A Little	Moderately	Quite A Bit	Extremely
44 Gloomy	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
45 Desperate	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
46 Sluggish	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
47 Rebellious	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
48 Helpless	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
49 Weary	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
50 Bewildered	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
51 Alert	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
52 Deceived	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
53 Furious	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
54 Efficient	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
55 Trusting	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
56 Full of pep	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
57 Bad-tempered	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
58 Worthless	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
59 Forgetful	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
60 Carefree	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
61 Terrified	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
62 Guilty	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
63 Vigorous	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
64 Uncertain about things	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
65 Bused	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

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Date completed: ____/____/____ OR Not done → Specify reason (use codelist below): _____
day month year

Perceived Stress Scale (PSS)

Instructions: The questions in this scale ask you about your feelings and thoughts during the last month. In each case, please indicate how often you felt or thought a certain way. Please check only one answer for each question.

	Never	Almost Never	Some- times	Fairly Often	Very Often
1 In the last month, how often have you felt that you were unable to control the important things in your life?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
2 In the last month, how often have you felt confident about your ability to handle your personal problems?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
3 In the last month, how often have you felt that things were going your way?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
4 In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Participant's Initials: ____
first middle last

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Date completed: ____/____/____ OR Not done → Specify reason (use codelist below): _____
day month year

Pittsburgh Sleep Quality Index (PSQI)

Instructions: The following questions relate to your usual sleep habits during the past month only. Your answers should indicate the most accurate reply for the majority of days and nights in the past month. Please answer all questions.

During the past month...

1 When have you usually gone to bed? _____ : _____
00:00 to 23:59

2 How long (in minutes) has it taken you to fall asleep each night? _____ minutes

3 When have you usually gotten up in the morning? _____ : _____
00:00 to 23:59

4 How many hours of actual sleep did you get at night?
(This may be different than the number of hours you spend in bed.) ____ . ____ hours

5 During the past month, how often have you had trouble sleeping because you... (check only one answer per question)	Not during the past month	Less than once a week	Once or twice a week	3 or more times a week
a Cannot get to sleep within 30 minutes	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
b Wake up in the middle of the night or early morning	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
c Have to get up to use the bathroom	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
d Cannot breathe comfortably	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
e Cough or snore loudly	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
f Feel too cold	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
g Feel too hot	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
h Have bad dreams	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
i Have pain	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
j Other reason(s), please describe, including how often you have had trouble sleeping because of this reason(s): _____	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃

6 During the past month, how often have you taken medicine (prescribed or "over the counter") to help you sleep? _____
0 1 2 3

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Pittsburgh Sleep Quality Index (PSQI) (continued)

	Never	Once or twice	Once or twice each week	3 or more times each week
7 During the past month, how often have you had trouble staying awake while driving, eating meals, or engaging in social activity?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
	No problem at all	Only a very slight problem	Somewhat of a problem	A very big problem
8 During the past month, how much of a problem has it been for you to keep up enthusiasm to get things done?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
	Very good	Fairly good	Fairly bad	Very bad
9 During the past month, how would you rate your sleep quality overall?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃

Participant's Initials: first middle last _____

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Date completed: ____/____/____ OR Not done → Specify reason (use codelist below): _____
day month year

Derogatis Interview for Sexual Function (DISF-SR) (F) Female Version

Instruction: Below you will find a brief set of questions about your sexual activities. The questions are divided into different sections that ask about different aspects of your sexual experiences. One section asks about **sexual fantasies** or daydreams, while another inquires about the kinds of **sexual experiences** that you have. You are also asked about the nature of your **sexual arousal** and the quality of your **orgasm**. There are also a few other questions about different areas of your sexual relationship.

On some questions you are asked to respond in terms of a frequency scale, that is, "how often" do you perform the sexual activities asked about in that section. Some frequency scales go from "0 = not at all" to "8 = four or more times a day." Other frequency scales range from "0 = never" to "4 = always." In the case of other questions, you will be asked to respond in terms of a satisfaction scale. This type of scale tells how much you enjoyed, or were satisfied by the sexual activity being asked about. Some satisfaction scales range from "0 = could not be worse" to "8 = could not be better." Other satisfaction scales go from "0 = not at all satisfied," to "4 = extremely satisfied."

In every section of the inventory the scales required for that section are printed just above the questions so it will be easy to follow. Although it is brief, take your time with the inventory. **For each item, please check the scale number that best describes your personal experience.**

If you have any questions, please ask the person who gave you the inventory for help.

Section 1—Sexual Cognition/Fantasy

During the past 30 days or since the last time you filled out this inventory, how often have you had thoughts, dreams, or fantasies about:	Not at all	Less than 1 per month	1 or 2 per month	1 per week	2 or 3 per week	4 to 6 per week	1 per day	2 or 3 per day	4 or more per day
1.1 A sexually attractive person	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
1.2 Erotic parts of a man's body (e.g., face, shoulders, legs)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
1.3 Erotic or romantic situations	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
1.4 Caressing, touching, undressing, or foreplay	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
1.5 Sexual intercourse, oral sex, touching to orgasm	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈

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Derogatis Interview for Sexual Function (DISF-SR) (F) Female Version (continued)

Section 2—Sexual Arousal

During the past 30 days or since the last time you filled out this inventory, how often did you have the following experiences?	Not at all	Less than 1 per month	1 or 2 per month	1 per week	2 or 3 per week	4 to 6 per week	1 per day	2 or 3 per day	4 or more per day
2.1 Feel sexually aroused while alone	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
2.2 Actively seek sexual satisfaction	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
2.3 Feel sexually aroused with a partner	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
	Never	Rarely	Sometimes	Usually	Always				
2.4 Have normal lubrication with masturbation	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄				
2.5 Have normal lubrication throughout sexual relations	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄				

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Derogatis Interview for Sexual Function (DISF-SR) (F) Female Version (continued)

Section 3—Sexual Behavior/Experiences

During the past 30 days or since the last time you filled out the inventory, how often did you engage in the following sexual activities?	Not at all	Less than 1 per month	1 or 2 per month	1 per week	2 or 3 per week	4 to 6 per week	1 per day	2 or 3 per day	4 or more per day
3.1 Reading or viewing romantic or erotic books or stories	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
3.2 Masturbation	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
3.3 Casual kissing and petting	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
3.4 Sexual foreplay	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
3.5 Sexual intercourse, oral sex, etc.	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈

Section 4—Orgasm

During the past 30 days or since the last time you filled out this inventory, how satisfied have you been with the following?	Not at all	Slightly	Moderately	Highly	Extremely
4.1 Your ability to have an orgasm	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
4.2 The intensity of your orgasm	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
4.3 The ability to have multiple orgasms (if typical for you)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
4.4 Feelings of closeness and togetherness with your partner	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
4.5 Your sense of control (timing) of your orgasm	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
4.6 Feeling a sense of relaxation and well-being after orgasm	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

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Derogatis Interview for Sexual Function (DISF-SR) (F) Female Version (continued)

Section 5—Drive and Relationship

	Not at all	Less than 1 per month	1 or 2 per month	1 per week	2 or 3 per week	4 to 6 per week	1 per day	2 or 3 per day	4 or more per day
5.1 With the partner of your choice, what would be your ideal frequency of sexual intercourse?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
	Not at all	Slightly	Moderately	Highly	Extremely				
5.2 During this period, how interested have you been in sex?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄				
5.3 During this period, how satisfied have you been with your personal relationship with your sexual partner?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄				
	Could not be worse	Very poor	Poor	Somewhat inadequate	Adequate	Above average	Good	Very good	Could not be better
5.4 In general, what would represent the best description of the quality of your sexual functioning?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈

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Derogatis Interview for Sexual Function (DISF-SR) (M) Male Version

Instruction: Below you will find a brief set of questions about your sexual activities. The questions are divided into different sections that ask about different aspects of your sexual experiences. One section asks about **sexual fantasies** or daydreams, while another inquires about the kinds of **sexual experiences** that you have. You are also asked about the nature of your **sexual arousal** and the quality of your **orgasm**. There are also a few other questions about different areas of your sexual relationship.

On some questions you are asked to respond in terms of a frequency scale, that is, "how often" do you perform the sexual activities asked about in that section. Some frequency scales go from "0 = not at all" to "8 = four or more times a day." Other frequency scales range from "0 = never" to "4 = always." In the case of other questions, you will be asked to respond in terms of a satisfaction scale. This type of scale tells how much you enjoyed, or were satisfied by the sexual activity being asked about. Some satisfaction scales range from "0 = could not be worse" to "8 = could not be better." Other satisfaction scales go from "0 = not at all satisfied," to "4 = extremely satisfied."

In every section of the inventory the scales required for that section are printed just above the questions so it will be easy to follow. Although it is brief, take your time with the inventory. **For each item, please check the scale number that best describes your personal experience.**

If you have any questions, please ask the person who gave you the inventory for help.

Section 1—Sexual Cognition/Fantasy

During the past 30 days or since the last time you filled out this inventory, how often have you had thoughts, dreams, or fantasies about:	Not at all	Less than 1 per month	1 or 2 per month	1 per week	2 or 3 per week	4 to 6 per week	1 per day	2 or 3 per day	4 or more per day
1.1 A sexually attractive person	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
1.2 Erotic parts of a woman's body (e.g., face, genitals, legs)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
1.3 Erotic or romantic situations	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
1.4 Caressing, touching, undressing, or foreplay	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
1.5 Sexual intercourse, oral sex, touching to orgasm	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈

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Derogatis Interview for Sexual Function (DISF-SR) (M) Male Version (continued)

Section 2—Sexual Arousal

During the past 30 days or since the last time you filled out this inventory, how often did you have the following experiences?	Not at all	Less than 1 per month	1 or 2 per month	1 per week	2 or 3 per week	4 to 6 per week	1 per day	2 or 3 per day	4 or more per day
2.1 A full erection upon awakening	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
2.2 A full erection during a sexual fantasy or daydream	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
2.3 A full erection while looking at a sexually arousing person, movie, or picture	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
2.4 A full erection during masturbation	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
2.5 A full erection throughout the phases of a normal sexual response cycle, that is from undressing and foreplay through intercourse and orgasm	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈

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Derogatis Interview for Sexual Function (DISF-SR) (M) Male Version (continued)

Section 3—Sexual Behavior/Experiences

During the past 30 days or since the last time you filled out the inventory, how often did you engage in the following sexual activities?	Not at all	Less than 1 per month	1 or 2 per month	1 per week	2 or 3 per week	4 to 6 per week	1 per day	2 or 3 per day	4 or more per day
3.1 Reading or viewing romantic or erotic books or stories	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
3.2 Masturbation	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
3.3 Casual kissing and petting	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
3.4 Sexual foreplay	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
3.5 Sexual intercourse, oral sex, etc.	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈

Section 4—Orgasm

During the past 30 days or since the last time you filled out this inventory, how <u>satisfied</u> have you been with the following?	Not at all	Slightly	Moderately	Highly	Extremely
4.1 Your ability to have an orgasm	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
4.2 The intensity of your orgasm	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
4.3 The length or duration of your orgasm	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
4.4 The amount of seminal liquid that you ejaculate	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
4.5 Your sense of control (timing) of your orgasm	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
4.6 Feeling a sense of relaxation and well-being after orgasm	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

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Derogatis Interview for Sexual Function (DISF-SR) (M) Male Version (continued)

Section 5—Drive and Relationship

	Not at all	Less than 1 per month	1 or 2 per month	1 per week	2 or 3 per week	4 to 6 per week	1 per day	2 or 3 per day	4 or more per day
5.1 With the partner of your choice, what would be your ideal frequency of sexual intercourse?	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4	<input type="checkbox"/> _5	<input type="checkbox"/> _6	<input type="checkbox"/> _7	<input type="checkbox"/> _8
	Not at all	Slightly	Moderately	Highly	Extremely				
5.2 During this period, how interested have you been in sex?	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4				
5.3 During this period, how satisfied have you been with your personal relationship with your sexual partner?	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4				
	Could not be worse	Very poor	Poor	Somewhat inadequate	Adequate	Above average	Good	Very good	Could not be better
5.4 In general, what would represent the best description of the quality of your sexual functioning?	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4	<input type="checkbox"/> _5	<input type="checkbox"/> _6	<input type="checkbox"/> _7	<input type="checkbox"/> _8

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day month year

Food Cravings Questionnaire—State (FCQ—S)

Below is a list of comments made by people about their eating habits. Please check one answer for each comment that indicates how much you agree with the comment **right now, at this very moment**. Notice that some questions refer to foods in general while others refer to one or more specific foods. Please respond to each item as honestly as possible.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1 I have an intense desire to eat [one or more specific foods].	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
2 I'm craving [one or more specific foods].	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
3 I have an urge for [one or more specific foods]	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
4 Eating [one or more specific foods] would make things seem just perfect.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
5 If I were to eat what I am craving, I am sure my mood would improve.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
6 Eating [one or more specific foods] would feel wonderful.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
7 If I ate something, I wouldn't feel so sluggish and lethargic.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
8 Satisfying my craving would make me feel less grouchy and irritable.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
9 I would feel more alert if I could satisfy my craving.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
10 If I had [one or more specific foods], I could not stop eating it.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
11 My desire to eat [one or more specific foods] seems overpowering.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
12 I know I'm going to keep on thinking about [one or more specific foods] until I actually have it.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
13 I am hungry.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
14 If I ate right now, my stomach wouldn't feel as empty.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
15 I feel weak because of not eating.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

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Food Craving Inventory (FCI-II)

For each of the foods listed below, please check the appropriate box.

Note: A craving is defined as an intense desire to consume a particular food or food type that is difficult to resist.

Over the past month, how often have you experienced a craving for...	Never	Rarely (once or twice)	Sometimes	Often	Always/Almost Every Day
1 Cake	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
2 Pizza	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
3 Fried chicken	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
4 Gravy	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
5 Sandwich bread	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
6 Sausage	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
7 French fries	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
8 Cinnamon rolls	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
9 Rice	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
10 Hot dog	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
11 Hamburger	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
12 Biscuits	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
13 Ice cream	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
14 Pasta	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
15 Fried fish	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
16 Cookies	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
17 Chocolate	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
18 Pancakes or waffles	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
19 Corn bread	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
20 Chips	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
21 Rolls	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
22 Cereal	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
23 Donuts	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
24 Candy	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
25 Brownies	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
26 Bacon	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
27 Steak	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
28 Baked potato	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

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day month year

Eating Inventory

- | | | | |
|----|--|--|---|
| 1 | When I smell a sizzling steak or see a juicy piece of meat, I find it very difficult to keep from eating, even if I have just finished a meal. | <input type="checkbox"/> ₁ True | <input type="checkbox"/> ₀ False |
| 2 | I usually eat too much at social occasions, like parties and picnics. | <input type="checkbox"/> ₁ True | <input type="checkbox"/> ₀ False |
| 3 | I am usually so hungry that I eat more than three times a day. | <input type="checkbox"/> ₁ True | <input type="checkbox"/> ₀ False |
| 4 | When I have eaten my quota of calories, I am usually good about not eating anymore. | <input type="checkbox"/> ₁ True | <input type="checkbox"/> ₀ False |
| 5 | Dieting is so hard for me because I just get too hungry. | <input type="checkbox"/> ₁ True | <input type="checkbox"/> ₀ False |
| 6 | I deliberately take small helpings as a means of controlling my weight. | <input type="checkbox"/> ₁ True | <input type="checkbox"/> ₀ False |
| 7 | Sometimes things just taste so good that I keep on eating even when I am no longer hungry. | <input type="checkbox"/> ₁ True | <input type="checkbox"/> ₀ False |
| 8 | Since I am often hungry, I sometimes wish that while I am eating, an expert would tell me that I have had enough or that I can have something more to eat. | <input type="checkbox"/> ₁ True | <input type="checkbox"/> ₀ False |
| 9 | When I feel anxious, I find myself eating. | <input type="checkbox"/> ₁ True | <input type="checkbox"/> ₀ False |
| 10 | Life is too short to worry about dieting. | <input type="checkbox"/> ₁ True | <input type="checkbox"/> ₀ False |
| 11 | Since my weight goes up and down, I have gone on reducing diets more than once. | <input type="checkbox"/> ₁ True | <input type="checkbox"/> ₀ False |
| 12 | I often feel so hungry that I just have to eat something. | <input type="checkbox"/> ₁ True | <input type="checkbox"/> ₀ False |
| 13 | When I am with someone who is overeating, I usually overeat too. | <input type="checkbox"/> ₁ True | <input type="checkbox"/> ₀ False |
| 14 | I have a pretty good idea of the number of calories in common food. | <input type="checkbox"/> ₁ True | <input type="checkbox"/> ₀ False |
| 15 | Sometimes when I start eating, I just can't seem to stop. | <input type="checkbox"/> ₁ True | <input type="checkbox"/> ₀ False |
| 16 | It is not difficult for me to leave something on my plate. | <input type="checkbox"/> ₁ True | <input type="checkbox"/> ₀ False |
| 17 | At certain times of the day, I get hungry because I have gotten used to eating then. | <input type="checkbox"/> ₁ True | <input type="checkbox"/> ₀ False |
| 18 | While on a diet, if I eat food that is not allowed, I consciously eat less for a period of time to make up for it. | <input type="checkbox"/> ₁ True | <input type="checkbox"/> ₀ False |

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Eating Inventory (continued)

- 19** Being with someone who is eating often makes me hungry to eat also. True False
- 20** When I feel blue, I often overeat. True False
- 21** I enjoy eating too much to spoil it by counting calories or watching my weight. True False
- 22** When I see a real delicacy, I often get so hungry that I have to eat right away. True False
- 23** I often stop eating when I am not really full as a conscious means of limiting the amount I eat. True False
- 24** I get so hungry that my stomach often seems like a bottomless pit. True False
- 25** My weight has hardly changed at all in the last ten years. True False
- 26** I am always hungry so it is hard for me to stop eating before I finish the food on my plate. True False
- 27** When I feel lonely, I console myself by eating. True False
- 28** I consciously hold back at meals in order not to gain weight. True False
- 29** I sometimes get very hungry late in the evening or at night. True False
- 30** I eat anything I want, any time I want. True False
- 31** Without even thinking about it, I take a long time to eat. True False
- 32** I count calories as a conscious means of controlling my weight. True False
- 33** I do not eat some foods because they make me fat. True False
- 34** I am always hungry enough to eat at any time. True False
- 35** I pay a great deal of attention to changes in my figure. True False
- 36** While on a diet, if I eat a food that is not allowed, I often splurge and eat other high calorie foods. True False

Participant's Initials: first middle last _____

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first middle last

Eating Inventory (continued)

Please check one answer that is most appropriate to you for each question below.

37	How often are you dieting in a conscious effort to control your weight?	<input type="checkbox"/> ₁ Rarely	<input type="checkbox"/> ₂ Sometimes	<input type="checkbox"/> ₃ Usually	<input type="checkbox"/> ₄ Always		
38	Would a weight fluctuation of 5 pounds affect the way you live your life?	<input type="checkbox"/> ₁ Rarely	<input type="checkbox"/> ₂ Sometimes	<input type="checkbox"/> ₃ Usually	<input type="checkbox"/> ₄ Always		
39	How often do you feel hungry?	<input type="checkbox"/> ₁ Rarely	<input type="checkbox"/> ₂ Sometimes	<input type="checkbox"/> ₃ Usually	<input type="checkbox"/> ₄ Always		
40	Do your feelings of guilt about overeating help you to control your food intake?	<input type="checkbox"/> ₁ Rarely	<input type="checkbox"/> ₂ Sometimes	<input type="checkbox"/> ₃ Usually	<input type="checkbox"/> ₄ Always		
41	How difficult would it be for you to stop eating halfway through dinner and not eat for the next four hours?	<input type="checkbox"/> ₁ Easy	<input type="checkbox"/> ₂ Slightly difficult	<input type="checkbox"/> ₃ Moderately difficult	<input type="checkbox"/> ₄ Very difficult		
42	How conscious are you of what you are eating?	<input type="checkbox"/> ₁ Not at all	<input type="checkbox"/> ₂ Slightly	<input type="checkbox"/> ₃ Moderately	<input type="checkbox"/> ₄ Extremely		
43	How frequently do you avoid "stocking up" on tempting foods?	<input type="checkbox"/> ₁ Almost never	<input type="checkbox"/> ₂ Seldom	<input type="checkbox"/> ₃ Usually	<input type="checkbox"/> ₄ Almost always		
44	How likely are you to shop for low calorie foods?	<input type="checkbox"/> ₁ Unlikely	<input type="checkbox"/> ₂ Slightly likely	<input type="checkbox"/> ₃ Moderately likely	<input type="checkbox"/> ₄ Very likely		
45	Do you eat sensibly in front of others and splurge alone?	<input type="checkbox"/> ₁ Never	<input type="checkbox"/> ₂ Rarely	<input type="checkbox"/> ₃ Often	<input type="checkbox"/> ₄ Always		
46	How likely are you to consciously eat slowly in order to cut down on how much you eat?	<input type="checkbox"/> ₁ Unlikely	<input type="checkbox"/> ₂ Slightly likely	<input type="checkbox"/> ₃ Moderately likely	<input type="checkbox"/> ₄ Very likely		
47	How frequently do you skip dessert because you are no longer hungry?	<input type="checkbox"/> ₁ Almost never	<input type="checkbox"/> ₂ Seldom	<input type="checkbox"/> ₃ At least once a week	<input type="checkbox"/> ₄ Almost every day		
48	How likely are you to consciously eat less than you want?	<input type="checkbox"/> ₁ Unlikely	<input type="checkbox"/> ₂ Slightly likely	<input type="checkbox"/> ₃ Moderately likely	<input type="checkbox"/> ₄ Very likely		
49	Do you go on eating binges though you are not hungry?	<input type="checkbox"/> ₁ Never	<input type="checkbox"/> ₂ Rarely	<input type="checkbox"/> ₃ Sometimes	<input type="checkbox"/> ₄ At least once a week		
50	To what extent does this statement describe your eating behavior? "I start dieting in the morning, but because of any number of things that happen during the day, by evening I have given up and eat what I want, promising myself to start dieting again tomorrow."	<input type="checkbox"/> ₁ Not like me	<input type="checkbox"/> ₂ Little like me	<input type="checkbox"/> ₃ Pretty good description of me	<input type="checkbox"/> ₄ Describes me perfectly		
51	On a scale of 0 to 5, where 0 means no restraint in eating (eating whatever you want, whenever you want it) and 5 means total restraint (constantly limiting food intake and never "giving in"), what number would you give yourself?	<input type="checkbox"/> ₀ Eat whatever you want, whenever you want it	<input type="checkbox"/> ₁ Usually eat whatever you want, whenever you want it	<input type="checkbox"/> ₂ Often eat whatever you want, whenever you want it	<input type="checkbox"/> ₃ Often limit food intake, but often "give in"	<input type="checkbox"/> ₄ Usually limit food intake, rarely "give in"	<input type="checkbox"/> ₅ Constantly limiting food intake, never "giving in"

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day month year

Weight Efficacy Lifestyle Questionnaire (WEL)

This form describes some typical eating situations. Everyone has situations which make it very hard for them to keep their weight down. The following are a number of situations relating to eating patterns and attitudes. This form will help you to identify the eating situations which you find the hardest to manage.

Read each situation listed below and decide how confident (or certain) you are that you will be able to resist eating in each of the difficult situations. In other words, pretend that you are in the eating situation right now. On a scale from 0 (not confident) to 9 (very confident), choose ONE number that reflects how confident you feel now about being able to **successfully resist** the desire to eat. Check this number for each item.

I am confident that:	Not confident at all that you can resist the desire to eat					Very confident that you can resist the desire to eat				
	0	1	2	3	4	5	6	7	8	9
1 I can resist eating when I am anxious (nervous).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 I can control my eating on the weekends.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 I can resist eating even when I have to say "no" to others.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 I can resist eating when I feel physically run down.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 I can resist eating when I am watching TV.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 I can resist eating when I am depressed (or down).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7 I can resist eating when there are many different kinds of food available.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8 I can resist eating even when I feel it is impolite to refuse a second helping.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9 I can resist eating even when I have a headache.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Participant's Initials: _____
first middle last

Center Number: ____ Participant Number: ____ Participant's Initials:
first middle last

Weight Efficacy Lifestyle Questionnaire (WEL) (continued)

I am confident that:	Not confident at all that you can resist the desire to eat					Very confident that you can resist the desire to eat				
	0	1	2	3	4	5	6	7	8	9
10 I can resist eating when I am reading.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 I can resist eating when I am angry (or irritable).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12 I can resist eating even when I am at a party.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13 I can resist eating even when others are pressuring me to eat.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14 I can resist eating when I am in pain.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15 I can resist eating just before going to bed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16 I can resist eating when I have experienced failure.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17 I can resist eating when high-calorie foods are available.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18 I can resist eating even when I think others will be upset if I don't eat.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19 I can resist eating when I feel uncomfortable.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20 I can resist eating when I am happy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Participant's Initials:
first middle last

Center Number: ____ Participant Number: _____ Participant's Initials: _____
first middle last

Date completed: ____/____/____ OR Not done → Specify reason (use codelist below): _____
day month year

Multiaxial Assessment of Eating Disorder Symptoms (MAEDS)

Instructions: Using the scale shown, please rate the following items on a scale from 1 to 7. Please answer as truthfully as possible.

	Never	Very Rarely	Rarely	Sometimes	Often	Very Often	Always
1 Fasting is a good way to lose weight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
2 My sleep isn't as good as it used to be.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
3 I avoid eating for as long as I can.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
4 Certain foods are "forbidden" for me to eat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
5 I can't keep certain foods in my house because I will binge on them.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
6 I can easily make myself vomit.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
7 I can feel that being fat is terrible.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
8 I avoid greasy foods.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
9 It's okay to binge and purge once in a while.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
10 I don't eat certain foods.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
11 I think I am a good person.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
12 My eating is normal.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
13 I can't seem to concentrate lately.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
14 I try to diet by fasting.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
15 I vomit to control my weight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
16 Lately nothing seems enjoyable anymore.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
17 Laxatives help keep you slim.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
18 I don't eat red meat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
19 I eat so rapidly I can't even taste my food.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇

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Multiaxial Assessment of Eating Disorder Symptoms (MAEDS) (continued)

	Never	Very Rarely	Rarely	Some-times	Often	Very Often	Always
20 I do everything I can to avoid being overweight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
21 When I feel bloated, I must do something to rid myself of that feeling.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
22 I overeat too frequently.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
23 It's okay to be overweight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
24 Recently I have felt that I am a worthless person.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
25 I would be very upset if I gained 2 pounds.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
26 I crave sweets and carbohydrates.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
27 I lose control when I eat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
28 Being fat would be terrible.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
29 I have thought seriously about suicide lately.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
30 I don't have any energy anymore.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
31 I eat small portions to control my weight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
32 I eat 3 meals a day.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
33 Lately I have been easily irritated.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
34 Some foods should be totally avoided.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
35 I use laxatives to control my weight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
36 I am terrified by the thought of being overweight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
37 Purging is a good way to lose weight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
38 I avoid fatty foods.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇

Participant's Initials: _____
first middle last

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Multiaxial Assessment of Eating Disorder Symptoms (MAEDS) (continued)

	Never	Very Rarely	Rarely	Some-times	Often	Very Often	Always
39 Recently I have felt pretty blue.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
40 I am obsessed with becoming overweight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
41 I don't eat fried foods.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
42 I skip meals.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
43 Fat people are unhappy.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
44 People are too concerned with the way I eat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
45 I feel good when I skip meals.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
46 I avoid foods with sugar.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
47 I hate it when I feel fat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
48 I am too fat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
49 I eat until I am completely stuffed.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
50 I hate to eat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
51 I feel guilty about a lot of things these days.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
52 I'm very careful of what I eat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
53 I can "hold off" and not eat even if I am hungry.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
54 I eat even when I am not hungry.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
55 Fat people are disgusting.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
56 I wouldn't mind gaining a few pounds.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇

Participant's Initials: _____
first middle last

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Date completed: ____/____/____ OR Not done → Specify reason (use codelist below): _____
day month year

Body Shape Questionnaire (BSQ)

We would like to know how you have been feeling about your appearance over the **past four weeks**. Please read each question and check the box for the appropriate choice. Please answer all the questions.

Over the Past Four Weeks...	Never	Rarely	Some-times	Often	Very Often	Always
1 Has feeling bored made you brood about your shape?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
2 Have you been so worried about your shape that you have been feeling that you ought to diet?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
3 Have you thought that your thighs, hips, or bottom are too large for the rest of you?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
4 Have you been afraid that you might become fat (or fatter)?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
5 Have you worried about your flesh not being firm enough?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
6 Has feeling full (e.g., after eating a large meal) made you feel fat?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
7 Have you felt so bad about your shape that you have cried?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
8 Have you avoided running because your flesh might wobble?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
9 Has being with thin women/men made you feel self-conscious about your shape?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
10 Have you worried about your thighs spreading out when sitting down?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
11 Has eating even a small amount of food made you feel fat?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
12 Have you noticed the shape of other women/men and felt that your own shape compared unfavorably?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
13 Has thinking about your shape interfered with your ability to concentrate (e.g., while watching TV, reading, listening to conversations)?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
14 Has being naked, such as when taking a bath, made you feel fat?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
15 Have you avoided wearing clothes which make you particularly aware of the shape of your body?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
16 Have you imagined cutting off fleshy areas of your body?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Participant's Initials: _____
first middle last

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Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Body Shape Questionnaire (BSQ) (continued)

Over the Past Four Weeks...	Never	Rarely	Sometimes	Often	Very Often	Always
17 Has eating sweets, cakes or other high calorie food made you feel fat?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
18 Have you not gone out on social occasions (e.g., parties) because you have felt bad about your shape?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
19 Have you felt excessively large and rounded?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
20 Have you felt ashamed of your body?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
21 Has worry about your shape made you diet?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
22 Have you felt happiest about your shape when your stomach has been empty?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
23 Have you thought that you are the shape you are because you lack self-control?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
24 Have you worried about other people seeing rolls of flesh around your waist or stomach?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
25 Have you felt that it is not fair that other women/men are thinner than you?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
26 Have you vomited in order to feel thinner?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
27 When in company, have you worried about taking up too much room (e.g., sitting on a sofa or bus seat)?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
28 Have you worried about your flesh being dimply?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
29 Has seeing your reflection (e.g., in a mirror or shop window) made you feel bad about your shape?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
30 Have you pinched areas of your body to see how much fat is there?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
31 Have you avoided situations where people could see your body (e.g., communal changing rooms or swimming pools)?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
32 Have you taken laxatives in order to feel thinner?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
33 Have you been particularly self-conscious about your shape when in the company of other people?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
34 Has worry about your shape made you feel you ought to exercise?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆

Participant's Initials: _____
first middle last

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Center Number: ____ Participant Number: ____ Participant's Initials: first middle last

Clinic Weight

Weight date and time: ____/____/____ : ____
day month year 00:00 to 23:59

Staff initials: first middle last

OR Not done → Specify reason (use codelist below): _____

Clinic weight (if the first two measurements are more than 0.1 kg apart, measure weight a third time):

Weight 1: _____ . ____ kg

Weight 2: _____ . ____ kg

Weight 3: _____ . ____ kg

Weight of gown: _____ . ____ kg

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: _____ Participant Number: _____ Participant's Initials: _____

Seven-Day Physical Activity Recall (PAR)

Today's date: ____/____/____ Day (check only one): Mon Tues Wed Thurs Fri Sat Sun OR Not done → Specify reason (use code/1st below): _____

1 Were you employed in the last seven days? No → Skip to question 3 Yes

2 If Yes: Which days (check all that apply)? Mon Tues Wed Thurs Fri Sat Sun

3 Which days do you consider your weekend, or non-work, days? Mon Tues Wed Thurs Fri Sat Sun

Interviewer initials: _____

Day #	Day of Week	Date	Sleep Time		Work Time			Morning (in minutes)			Afternoon (in minutes)			Evening (in minutes)		
			In Bed	Up	Start	Stop	Mod.	Hard	Very Hard	Mod.	Hard	Very Hard	Mod.	Hard	Very Hard	
7	(yester- day)	____/____/____ day month year	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	
6		____/____/____ day month year	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	
5		____/____/____ day month year	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	
4		____/____/____ day month year	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	
3		____/____/____ day month year	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	
2		____/____/____ day month year	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	
1	(1 week ago)	____/____/____ day month year	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: ____ Participant Number: ____ Participant's Initials: first middle last ____

Seven-Day Physical Activity Recall (PAR) (continued)

4 Compared to your physical activity over the past three months, was last week's physical activity more, less, or about the same (check only one)?

- ₁ More
₂ Less
₃ About the same

Interviewer: Please answer questions below and note any comments on interview.

5 Were there any problems with the Seven-Day PAR interview?

- ₀ No
₁ Yes

6 Do you think this was a valid Seven-Day PAR interview?

- ₀ No
₁ Yes

7 Were there any activities reported by the participant that you don't know how to classify?

- ₀ No
₁ Yes

Center Number: ____ Participant Number: ____ Participant's Initials: first middle last ____

6-Day Food Record

Complete below OR Not done → Specify reason (use Codelist below): _____ Staff initials: first middle last ____

			Replacement Values		
Day of DLW	Date of Record	Record Quality (check only one)	Day of DLW	Date of Record	Record Quality (check only one)
1	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing	8	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing
2	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing	9	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing
3	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing	10	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing
4	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing	11	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing
5	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing	12	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing
6	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing	13	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Outcomes Labs

Date and time of last meal: _____ / _____ / _____ : _____
day month year 00:00 to 23:59

Date and time sample collection started: _____ / _____ / _____ : _____
day month year 00:00 to 23:59

Sample	Sample Complete?	If Not Done, Reason (Use codelist below)	Staff Initials
Blood	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	<small>first middle last</small>

If a sample is not obtained, indicate with a Not Done.

Core Temperature

Staff Initials	Provide Date of Sample Collection/Procedure	Time of Sample Collection/Procedure	If Not Done, Reason (Use codelist below)
<small>first middle last</small>	Start Date: _____ / _____ / _____ <small>day month year</small>	Start Time _____ : _____ <small>00:00 to 23:59</small>	_____
	Stop Date: _____ / _____ / _____ <small>day month year</small>	Stop Time _____ : _____ <small>00:00 to 23:59</small>	

Inpatient Admission and Discharge

1 Inpatient admission date and time: _____ / _____ / _____ : _____
day month year 00:00 to 23:59

2 Inpatient discharge date and time: _____ / _____ / _____ : _____
day month year 00:00 to 23:59

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: ____ Participant Number: ____ Participant's Initials: first middle last

Clinic Weight

Weight date and time: ____/____/____ : ____
day month year 00:00 to 23:59

Staff initials: first middle last

OR Not done → Specify reason (use codelist below): ____

Clinic weight (if the two measurements are more than 0.1 kg apart, measure weight a third time):

Weight 1: ____ . ____ kg

Weight 2: ____ . ____ kg

Weight 3: ____ . ____ kg

Weight of gown: ____ . ____ kg

Pregnancy Test

Complete only for females.

Does participant have reproductive potential?

₀ No

₁ Yes → If Yes: Date urine pregnancy test performed: ____/____/____
day month year

Results: ₁ Negative

₂ Positive

Center Number: ____ Participant Number: ____ Participant's Initials:
first middle last

DXA Scan

- 1** Has the participant taken a calcium supplement today?
₀ No ₁ Yes → If Yes: Proceed with scan and document in the Subject Scan Log to inform the QA Center.
- 2** Were any studies involving barium or radioisotopes performed within 4 weeks prior to the scheduled DXA exam?
₀ No ₁ Yes

DXA Scan		DXA Rescan OR <input type="checkbox"/> ₉₆ NA
Date of scan: ____/____/____ <small>day month year</small>		Date of rescan: ____/____/____ <small>day month year</small>
Area Scanned Check all that apply	If Not Done, Reason (Use codelist below)	Area Scanned Check all that apply
<input type="checkbox"/> Whole body	_____	<input type="checkbox"/> Whole body

Metabolic Rate

Sample	Date of Collection	If Not Done, Reason (Use codelist below)	Staff Initials
Resting Metabolic Rate (RMR)—Visit 5	____/____/____ <small>day month year</small>	_____	<u> </u> <u> </u> <u> </u> <small>first middle last</small>
Cart ID	<input type="checkbox"/> Tufts-003 (623-002) <input type="checkbox"/> WASH U-001 (623-003) <input type="checkbox"/> PBRC-016 (623-005) <input type="checkbox"/> Tufts-006 (623-006) <input type="checkbox"/> WASH U-002 (623-004) <input type="checkbox"/> PBRC-017 (623-001)		

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Seven-Day Physical Activity Recall (PAR)

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Today's date: ___/___/___ Day (check only one): Mon Tues Wed Thurs Fri Sat Sun **OR Not done** → Specify reason (use code list below): _____

1 Were you employed in the last seven days? No → Skip to question 3 Yes
 Interviewer initials: _____
first middle last

2 If Yes: Which days (check all that apply)?
 Mon Tues Wed Thurs Fri Sat Sun

3 Which days do you consider your weekend, or non-work, days?
 Mon Tues Wed Thurs Fri Sat Sun

Day #	Day of Week	Date	Sleep Time		Work Time			Morning (in minutes)			Afternoon (in minutes)			Evening (in minutes)					
			In Bed	Up	Start	Stop	Mod.	Hard	Very Hard	Mod.	Hard	Very Hard	Mod.	Hard	Very Hard				
7	(yester-day)	___/___/___ <small>day month year</small>	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59														
6		___/___/___ <small>day month year</small>	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59														
5		___/___/___ <small>day month year</small>	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59														
4		___/___/___ <small>day month year</small>	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59														
3		___/___/___ <small>day month year</small>	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59														
2		___/___/___ <small>day month year</small>	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59														
1	(1 week ago)	___/___/___ <small>day month year</small>	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59														

Not Done Code list: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: ____ Participant Number: ____ Participant's Initials: first middle last ____

Seven-Day Physical Activity Recall (PAR) (continued)

4 Compared to your physical activity over the past three months, was last week's physical activity more, less, or about the same (check only one)?

- ₁ More
₂ Less
₃ About the same

Interviewer: Please answer questions below and note any comments on interview.

5 Were there any problems with the Seven-Day PAR interview?

- ₀ No
₁ Yes

6 Do you think this was a valid Seven-Day PAR interview?

- ₀ No
₁ Yes

7 Were there any activities reported by the participant that you don't know how to classify?

- ₀ No
₁ Yes

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Clinic Weight

Weight date and time: _____ / _____ / _____ : _____
day month year 00:00 to 23:59

Staff initials: _____
first middle last

OR Not done → Specify reason (use Codelist below): _____

Clinic weight (if the first two measurements are more than 0.1 kg apart, measure weight a third time):

Weight 1: _____ . _____ kg

Weight 2: _____ . _____ kg

Weight 3: _____ . _____ kg

Weight of gown: _____ . _____ kg

Vital Signs

Assessment date and time: _____ / _____ / _____ : _____
day month year 00:00 to 23:59

If waist measurement not done → Specify reason (use codelist below): _____

1 Natural waist measurement

(if the first two measurements are more than 1.0 cm apart, measure natural waist circumference a third time):

Staff initials: _____
first middle last

Natural waist measurement 1: _____ . _____ cm

Natural waist measurement 2: _____ . _____ cm

Natural waist measurement 3: _____ . _____ cm

2 Umbilical point waist measurement (if the first two measurements are more than 1.0 cm apart, measure umbilical point waist circumference a third time):

Umbilical point waist measurement 1: _____ . _____ cm

Umbilical point waist measurement 2: _____ . _____ cm

Umbilical point waist measurement 3: _____ . _____ cm

3 Pulse: _____ bpm OR Not done → Specify reason (use codelist below): _____

Staff initials: _____
first middle last

4 Temperature: _____ . _____ °C OR Not done → Specify reason (use codelist below): _____

Staff initials: _____
first middle last

5 Respirations: _____ per minute OR Not done → Specify reason (use codelist below): _____

Staff initials: _____
first middle last

6 Blood pressure (check only one): ₁ Left arm ₂ Right arm

Staff initials: _____
first middle last

6a Blood pressure 1: _____ / _____ mm Hg Time: _____ : _____
systolic diastolic 00:00 to 23:59 OR Not done → Specify reason (use codelist below): _____

6b Blood pressure 2: _____ / _____ mm Hg Time: _____ : _____
systolic diastolic 00:00 to 23:59

6c Blood pressure 3: _____ / _____ mm Hg Time: _____ : _____
systolic diastolic 00:00 to 23:59

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

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Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

12-Lead ECG

Date and Time	Findings	Staff Initials
____ / ____ / ____ : ____ <small>day month year 00:00 to 23:59</small> OR Not done → Specify reason <small>(see codelist below):</small> _____	Is ECG (check only one): <input type="checkbox"/> ₁ Normal <input type="checkbox"/> ₂ Abnormal, not clinically significant (specify): _____ _____ <input type="checkbox"/> ₃ Abnormal, clinically significant (specify): _____ _____	 <small>first middle last</small>

Safety Labs

Date and time of last meal: ____ / ____ / ____ : ____
day month year 00:00 to 23:59

Date and time of sample collection: ____ / ____ / ____ : ____
day month year 00:00 to 23:59

Sample	Sample Complete?	If Not Done, Reason <small>(Use codelist below)</small>	Staff Initials
Blood	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	_____	<small>first middle last</small>
Urine	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	_____	<small>first middle last</small>

Contraception

If Not Done → Specify reason (use codelist below): _____

Contraception method (females only):

- None OR Check all that apply:
- Oral contraceptive → Specify: _____
Record on Concomitant Medications page
 - Other → Specify (e.g., barrier, IUD): _____

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: ____ Participant Number: ____ Participant's Initials: first middle last ____

Date completed: ____/____/____ OR Not done → Specify reason (use codelist below): ____
day month year

BDI-II

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully and then pick out the one statement in each group that best describes the way you have been feeling during the past two weeks, including today. Check the box beside the statement you have picked. Be sure that you check only one statement for each group, including item 16 and item 18.

- 1 Sadness:** ₀ I do not feel sad
₁ I feel sad much of the time
₂ I am sad all of the time
₃ I am so sad or unhappy that I can't stand it
- 2 Pessimism:** ₀ I am not discouraged about my future
₁ I feel more discouraged about my future than I used to be
₂ I do not expect things to work out for me
₃ I feel my future is hopeless and will only get worse
- 3 Past failure:** ₀ I do not feel like a failure
₁ I have failed more than I should have
₂ As I look back, I see a lot of failures
₃ I feel I am a total failure as a person
- 4 Loss of pleasure:** ₀ I get as much pleasure as I ever did from the things I enjoy
₁ I don't enjoy things as much as I used to
₂ I get very little pleasure from the things I used to enjoy
₃ I can't get any pleasure from the things I used to enjoy
- 5 Guilty feelings:** ₀ I don't feel particularly guilty
₁ I feel guilty over many things I have done or should have done
₂ I feel quite guilty most of the time
₃ I feel guilty all of the time
- 6 Punishment feelings:** ₀ I don't feel I am being punished
₁ I feel I may be punished
₂ I expect to be punished
₃ I feel I am being punished
- 7 Self-dislike:** ₀ I feel the same about myself as ever
₁ I have lost confidence in myself
₂ I am disappointed in myself
₃ I dislike myself

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Participant's Initials: first middle last ____

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Center Number: ____ Participant Number: ____ Participant's Initials:
first middle last

BDI-II (continued)

- 8 Self-criticalness:**
- ₀ I don't criticize or blame myself more than usual
 - ₁ I am more critical of myself than I used to be
 - ₂ I criticize myself for all of my faults
 - ₃ I blame myself for everything bad that happens
- 9 Suicidal thoughts or wishes:**
- ₀ I don't have any thoughts of killing myself
 - ₁ I have thoughts of killing myself but I would not carry them out
 - ₂ I would like to kill myself
 - ₃ I would kill myself if I had the chance
- 10 Crying:**
- ₀ I don't cry any more than I used to
 - ₁ I cry more than I used to
 - ₂ I cry over every little thing
 - ₃ I feel like crying, but I can't
- 11 Agitation:**
- ₀ I am no more wound up or restless than usual
 - ₁ I feel more restless or wound up than usual
 - ₂ I am so restless or agitated that it's hard to stay still
 - ₃ I am so restless or agitated that I have to keep moving or doing something
- 12 Loss of interest:**
- ₀ I have not lost interest in other people or activities
 - ₁ I am less interested in other people or things than before
 - ₂ I have lost most of my interest in other people or things
 - ₃ It's hard to get interested in anything
- 13 Indecisiveness:**
- ₀ I make decisions about as well as ever
 - ₁ I find it more difficult to make decisions than usual
 - ₂ I have much greater difficulty in making decisions than I used to
 - ₃ I have trouble making my decisions
- 14 Worthlessness:**
- ₀ I do not feel I am worthless
 - ₁ I don't consider myself as worthwhile and useful as I used to
 - ₂ I feel more worthless as compared to other people
 - ₃ I feel utterly worthless
- 15 Loss of energy:**
- ₀ I have as much energy as ever
 - ₁ I have less energy than I used to have
 - ₂ I don't have enough energy to do very much
 - ₃ I don't have enough energy to do anything

Participant's Initials:
first middle last

Center Number: ____ Participant Number: ____ Participant's Initials:
first middle last

BDI-II (continued)

- 16 Changes in sleeping pattern:**
- ₀ I have not experienced any change in my sleeping pattern
 - ₁ I sleep somewhat more than usual
 - ₂ I sleep somewhat less than usual
 - ₃ I sleep a lot more than usual
 - ₄ I sleep a lot less than usual
 - ₅ I sleep most of the day
 - ₆ I wake up 1-2 hours early and can't get back to sleep

- 17 Irritability:**
- ₀ I am no more irritable than usual
 - ₁ I am more irritable than usual
 - ₂ I am much more irritable than usual
 - ₃ I am irritable all of the time

- 18 Changes in appetite:**
- ₀ I have not experienced any change in my appetite
 - ₁ My appetite is somewhat less than usual
 - ₂ My appetite is somewhat greater than usual
 - ₃ My appetite is much less than before
 - ₄ My appetite is much greater than usual
 - ₅ I have no appetite at all
 - ₆ I crave food all of the time

- 19 Concentration difficulty:**
- ₀ I can concentrate as well as ever
 - ₁ I can't concentrate as well as usual
 - ₂ It's hard to keep my mind on anything for very long
 - ₃ I find I can't concentrate on anything

- 20 Tiredness or fatigue:**
- ₀ I am no more tired or fatigued than usual
 - ₁ I get more tired or fatigued more easily than usual
 - ₂ I am too tired or fatigued to do a lot of the things I used to do
 - ₃ I am too tired or fatigued to do most of the things I used to do

- 21 Loss of interest in sex:**
- ₀ I have not noticed any recent change in my interest in sex
 - ₁ I am less interested in sex than I used to be
 - ₂ I am much less interested in sex now
 - ₃ I have lost interest in sex completely

Participant's Initials:
first middle last

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Clinic Weight

Weight date and time: ____/____/____ 00:00 to 23:59
day month year

Staff initials: _____
first middle last

OR Not done → Specify reason (use Codelist below): _____

Clinic weight (if the first two measurements are more than 0.1 kg apart, measure weight a third time):

Weight 1: _____ kg

Weight 2: _____ kg

Weight 3: _____ kg

Weight of gown: _____ kg

Vital Signs

Assessment date and time: ____/____/____ 00:00 to 23:59
day month year

If waist measurement not done → Specify reason (use codelist below): _____

1 Natural waist measurement
(if the first two measurements are more than 1.0 cm apart, measure natural waist circumference a third time):

Staff initials: _____
first middle last

Natural waist measurement 1: _____ cm

Natural waist measurement 2: _____ cm

Natural waist measurement 3: _____ cm

2 Umbilical point waist measurement (if the first two measurements are more than 1.0 cm apart, measure umbilical point waist circumference a third time):

Umbilical point waist measurement 1: _____ cm

Umbilical point waist measurement 2: _____ cm

Umbilical point waist measurement 3: _____ cm

3 Pulse: _____ bpm OR Not done → Specify reason (use codelist below): _____

Staff initials: _____
first middle last

4 Temperature: _____ °C OR Not done → Specify reason (use codelist below): _____

Staff initials: _____
first middle last

5 Respirations: _____ per minute OR Not done → Specify reason (use codelist below): _____

Staff initials: _____
first middle last

6 Blood pressure (check only one): ₁ Left arm ₂ Right arm

Staff initials: _____
first middle last

6a Blood pressure 1: _____/_____ mm Hg Time: _____:_____
systolic diastolic 00:00 to 23:59 OR Not done → Specify reason (use codelist below): _____

6b Blood pressure 2: _____/_____ mm Hg Time: _____:_____
systolic diastolic 00:00 to 23:59

6c Blood pressure 3: _____/_____ mm Hg Time: _____:_____
systolic diastolic 00:00 to 23:59

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

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Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

12-Lead ECG

Date and Time	Findings	Staff Initials
____ / ____ / ____ : ____ <small>day month year 00:00 to 23:59</small> OR Not done → Specify reason (see codelist below): _____	Is ECG (check only one): <input type="checkbox"/> ₁ Normal <input type="checkbox"/> ₂ Abnormal, not clinically significant (specify): _____ _____ <input type="checkbox"/> ₃ Abnormal, clinically significant (specify): _____ _____	_____ <small>first middle last</small>

Safety Labs

Date and time of last meal: ____ / ____ / ____ : ____
day month year 00:00 to 23:59

Date and time of sample collection: ____ / ____ / ____ : ____
day month year 00:00 to 23:59

Sample	Sample Complete?	If Not Done, Reason (Use codelist below)	Staff Initials
Blood	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	_____	_____ <small>first middle last</small>
Urine	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	_____	_____ <small>first middle last</small>

Pregnancy Test

Complete only for females.

Does participant have reproductive potential?

₀ No

₁ Yes → If Yes: Date urine pregnancy test performed: ____ / ____ / ____
day month year

Results: ₁ Negative

₂ Positive

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Doubly Labeled Water (DLW)

1 Date and time of DLW dosing: _____ / _____ / _____ : _____
day month year 00:00 to 23:59 Staff initials: _____
first middle last

OR Not done → Specify reason (use codelist below): _____

2 DLW dose mixture ID and bottle number: _____ - _____ - _____ - CA

3 Exact weight of DLW mixture: _____ . _____ grams

4 Urine samples:

Collection	Sample	Date and Time Collected
Pre dosing (PD)	PDa	_____ / _____ / _____ : _____ <small>day month year 00:00 to 23:59</small>
	PDb	_____ / _____ / _____ : _____ <small>day month year 00:00 to 23:59</small>
Day 0 (Visit 1)	D0a	_____ / _____ / _____ : _____ <small>day month year 00:00 to 23:59</small>
	D0b	_____ / _____ / _____ : _____ <small>day month year 00:00 to 23:59</small>
Day 7 (Visit 2)	D7a	_____ / _____ / _____ : _____ <small>day month year 00:00 to 23:59</small>
	D7b	_____ / _____ / _____ : _____ <small>day month year 00:00 to 23:59</small>
Day 14 (Visit 4)	D14a	_____ / _____ / _____ : _____ <small>day month year 00:00 to 23:59</small>
	D14b	_____ / _____ / _____ : _____ <small>day month year 00:00 to 23:59</small>

5 Affix CRF page label(s) corresponding to this urine sample set:

Affix
Test Sample
Label Here

Affix
Retest Sample
Label Here

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Physical Examination

Date of examination: ____/____/____
day month year

Staff initials: _____
first middle last

OR Not done → Specify reason (use codelist below): _____

Body System	Assessments			If Abnormal or Not Done: Explain
	Normal	Abnormal	Not Done	
1 General appearance:	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀ →	<input type="checkbox"/> ₉₇ →	
2 Head, Ears, Eyes, Nose, Throat:	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀ →	<input type="checkbox"/> ₉₇ →	
3 Neck:	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀ →	<input type="checkbox"/> ₉₇ →	
4 Heart:	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀ →	<input type="checkbox"/> ₉₇ →	
5 Lungs:	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀ →	<input type="checkbox"/> ₉₇ →	
6 Abdomen:	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀ →	<input type="checkbox"/> ₉₇ →	
7 Lymph nodes:	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀ →	<input type="checkbox"/> ₉₇ →	
8 Extremities/Skin:	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀ →	<input type="checkbox"/> ₉₇ →	
9 Neurological:	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀ →	<input type="checkbox"/> ₉₇ →	
10 Musculoskeletal:	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀ →	<input type="checkbox"/> ₉₇ →	
	Normal	Abnormal	Not Done *	
11 Genitourinary:	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀ →	<input type="checkbox"/> ₉₇ →	
12 Breast:	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀ →	<input type="checkbox"/> ₉₇ →	

Physician's Signature

Investigator: _____
signature

Date: ____/____/____
day month year

* Not done at this examination OR Referred participant to primary care physician for exam.

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

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Center Number: ____ Participant Number: ____ Participant's Initials: first middle last ____

DXA Scan

1 Has the participant taken a calcium supplement today?

₀ No ₁ Yes → If Yes: Proceed with scan and document in the Subject Scan Log to inform the QA Center.

2 Were any studies involving barium or radioisotopes performed within 4 weeks prior to the scheduled DXA exam?

₀ No ₁ Yes

DXA Scan		DXA Rescan OR <input type="checkbox"/> ₉₆ NA
Date of scan: ____/____/____ <small>day month year</small>		Date of rescan: ____/____/____ <small>day month year</small>
Area Scanned Check all that apply	If Not Done, Reason <i>(Use codelist below)</i>	Area Scanned Check all that apply
<input type="checkbox"/> Whole body	_____	<input type="checkbox"/> Whole body
<input type="checkbox"/> Forearm	_____	<input type="checkbox"/> Forearm
<input type="checkbox"/> Spine	_____	<input type="checkbox"/> Spine
<input type="checkbox"/> Hip	_____	<input type="checkbox"/> Hip

Center Number: ____ Participant Number: ____ Participant's Initials: first middle last ____

Date completed: ____/____/____ OR Not done → Specify reason (use codelist below): _____
day month year

RAND SF-36

Instructions: This survey asks for your views about your health. This information will help keep track of how well you are able to do your usual activities. Please answer every question by placing a check "X" in the appropriate box. If you are unsure about how to answer a question, give the best answer you can.

1 In general, would you say your health is: ₁ Excellent ₂ Very good ₃ Good ₄ Fair ₅ Poor

2 Compared to one year ago, how would you rate your health in general now? ₁ Much better now than 1 year ago
₂ Somewhat better now than 1 year ago
₃ About the same
₄ Somewhat worse now than 1 year ago
₅ Much worse now than 1 year ago

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes, Limited A Lot	Yes, Limited A Little	No, Not Limited At All
--	-----------------------	--------------------------	---------------------------

3 Vigorous activities , such as running, lifting heavy objects, participating in strenuous sports	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
---	---------------------------------------	---------------------------------------	---------------------------------------

4 Moderate activities , such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
--	---------------------------------------	---------------------------------------	---------------------------------------

5 Lifting or carrying groceries	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
--	---------------------------------------	---------------------------------------	---------------------------------------

6 Climbing several flights of stairs	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
--	---------------------------------------	---------------------------------------	---------------------------------------

7 Climbing one flight of stairs	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
---	---------------------------------------	---------------------------------------	---------------------------------------

8 Bending, kneeling or stooping	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
--	---------------------------------------	---------------------------------------	---------------------------------------

9 Walking more than a mile	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
--	---------------------------------------	---------------------------------------	---------------------------------------

10 Walking several blocks	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
---	---------------------------------------	---------------------------------------	---------------------------------------

11 Walking one block	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
------------------------------------	---------------------------------------	---------------------------------------	---------------------------------------

12 Bathing or dressing yourself	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
--	---------------------------------------	---------------------------------------	---------------------------------------

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Participant's Initials: first middle last ____

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Center Number: ____ Participant Number: ____ Participant's Initials: first middle last _____

Rand SF-36 (continued)

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

Yes **No**

13 Cut down on the **amount of time** you spent on work or other activities ₁ ₂

14 **Accomplished less** than you would like ₁ ₂

15 Were limited in the **kind** of work or other activities ₁ ₂

16 Had **difficulty** performing the work or other activities
(for example, it took extra effort) ₁ ₂

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)

Yes **No**

17 Cut down on the **amount of time** you spent on work or other activities ₁ ₂

18 **Accomplished less** than you would like ₁ ₂

19 Didn't do work or other activities as **carefully** as usual ₁ ₂

20 During the **past 4 weeks**, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors or groups?

₁ Not at all
₂ Slightly
₃ Moderately
₄ Quite a bit
₅ Extremely

21 How much **bodily** pain have you had during the **past 4 weeks**?

₁ None
₂ Very mild
₃ Mild
₄ Moderate
₅ Severe
₆ Very severe

22 During the **past 4 weeks**, how much did pain interfere with your normal work (including both work outside the home and housework)?

₁ Not at all
₂ A little bit
₃ Moderately
₄ Quite a bit
₅ Extremely

Participant's Initials: first middle last _____

Center Number: ____ Participant Number: ____ Participant's Initials: first middle last _____

RAND SF-36 (continued)

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks...	All of the Time	Most of the Time	A Good Bit of the Time	Some of the Time	A Little of the Time	None of the Time
23 Did you feel full of pep?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
24 Have you been a very nervous person?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
25 Have you felt so down in the dumps that nothing could cheer you up?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
26 Have you felt calm and peaceful?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
27 Did you have a lot of energy?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
28 Have you felt downhearted and blue?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
29 Did you feel worn out?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
30 Have you been a happy person?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
31 Did you feel tired?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
32 During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc)?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	
	All of the Time	Most of the Time	Some of the Time	A Little of the Time	None of the Time	
How true or false is each of the following statements for you?	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False	
33 I seem to get sick a little easier than other people.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	
34 I am healthy as anybody I know.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	
35 I expect my health to get worse.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	
36 My health is excellent.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	

Participant's Initials: first middle last _____

Center Number: ____ Participant Number: ____ Participant's Initials: first middle last ____

Date completed: ____/____/____ OR Not done → Specify reason (use codelist below): ____
day month year

BDI-II

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully and then pick out the one statement in each group that best describes the way you have been feeling during the past two weeks, including today. Check the box beside the statement you have picked. Be sure that you check only one statement for each group, including item 16 and item 18.

- 1 Sadness:** ₀ I do not feel sad
₁ I feel sad much of the time
₂ I am sad all of the time
₃ I am so sad or unhappy that I can't stand it
- 2 Pessimism:** ₀ I am not discouraged about my future
₁ I feel more discouraged about my future than I used to be
₂ I do not expect things to work out for me
₃ I feel my future is hopeless and will only get worse
- 3 Past failure:** ₀ I do not feel like a failure
₁ I have failed more than I should have
₂ As I look back, I see a lot of failures
₃ I feel I am a total failure as a person
- 4 Loss of pleasure:** ₀ I get as much pleasure as I ever did from the things I enjoy
₁ I don't enjoy things as much as I used to
₂ I get very little pleasure from the things I used to enjoy
₃ I can't get any pleasure from the things I used to enjoy
- 5 Guilty feelings:** ₀ I don't feel particularly guilty
₁ I feel guilty over many things I have done or should have done
₂ I feel quite guilty most of the time
₃ I feel guilty all of the time
- 6 Punishment feelings:** ₀ I don't feel I am being punished
₁ I feel I may be punished
₂ I expect to be punished
₃ I feel I am being punished
- 7 Self-dislike:** ₀ I feel the same about myself as ever
₁ I have lost confidence in myself
₂ I am disappointed in myself
₃ I dislike myself

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

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BDI-II (continued)

- 8 Self-criticalness:**
- ₀ I don't criticize or blame myself more than usual
 - ₁ I am more critical of myself than I used to be
 - ₂ I criticize myself for all of my faults
 - ₃ I blame myself for everything bad that happens
- 9 Suicidal thoughts or wishes:**
- ₀ I don't have any thoughts of killing myself
 - ₁ I have thoughts of killing myself but I would not carry them out
 - ₂ I would like to kill myself
 - ₃ I would kill myself if I had the chance
- 10 Crying:**
- ₀ I don't cry any more than I used to
 - ₁ I cry more than I used to
 - ₂ I cry over every little thing
 - ₃ I feel like crying, but I can't
- 11 Agitation:**
- ₀ I am no more wound up or restless than usual
 - ₁ I feel more restless or wound up than usual
 - ₂ I am so restless or agitated that it's hard to stay still
 - ₃ I am so restless or agitated that I have to keep moving or doing something
- 12 Loss of interest:**
- ₀ I have not lost interest in other people or activities
 - ₁ I am less interested in other people or things than before
 - ₂ I have lost most of my interest in other people or things
 - ₃ It's hard to get interested in anything
- 13 Indecisiveness:**
- ₀ I make decisions about as well as ever
 - ₁ I find it more difficult to make decisions than usual
 - ₂ I have much greater difficulty in making decisions than I used to
 - ₃ I have trouble making my decisions
- 14 Worthlessness:**
- ₀ I do not feel I am worthless
 - ₁ I don't consider myself as worthwhile and useful as I used to
 - ₂ I feel more worthless as compared to other people
 - ₃ I feel utterly worthless
- 15 Loss of energy:**
- ₀ I have as much energy as ever
 - ₁ I have less energy than I used to have
 - ₂ I don't have enough energy to do very much
 - ₃ I don't have enough energy to do anything

Participant's Initials: first middle last ____

Center Number: ____ Participant Number: ____ Participant's Initials: first middle last ____

BDI-II (continued)

- 16 Changes in sleeping pattern:**
- ₀ I have not experienced any change in my sleeping pattern
 - ₁ I sleep somewhat more than usual
 - ₂ I sleep somewhat less than usual
 - ₃ I sleep a lot more than usual
 - ₄ I sleep a lot less than usual
 - ₅ I sleep most of the day
 - ₆ I wake up 1-2 hours early and can't get back to sleep
- 17 Irritability:**
- ₀ I am no more irritable than usual
 - ₁ I am more irritable than usual
 - ₂ I am much more irritable than usual
 - ₃ I am irritable all of the time
- 18 Changes in appetite:**
- ₀ I have not experienced any change in my appetite
 - ₁ My appetite is somewhat less than usual
 - ₂ My appetite is somewhat greater than usual
 - ₃ My appetite is much less than before
 - ₄ My appetite is much greater than usual
 - ₅ I have no appetite at all
 - ₆ I crave food all of the time
- 19 Concentration difficulty:**
- ₀ I can concentrate as well as ever
 - ₁ I can't concentrate as well as usual
 - ₂ It's hard to keep my mind on anything for very long
 - ₃ I find I can't concentrate on anything
- 20 Tiredness or fatigue:**
- ₀ I am no more tired or fatigued than usual
 - ₁ I get more tired or fatigued more easily than usual
 - ₂ I am too tired or fatigued to do a lot of the things I used to do
 - ₃ I am too tired or fatigued to do most of the things I used to do
- 21 Loss of interest in sex:**
- ₀ I have not noticed any recent change in my interest in sex
 - ₁ I am less interested in sex than I used to be
 - ₂ I am much less interested in sex now
 - ₃ I have lost interest in sex completely

Participant's Initials: first middle last ____

Center Number: ____ Participant Number: ____ Participant's Initials:
first middle last

Date completed: ____/____/____ OR Not done → Specify reason (use codelist below): _____
day month year

Profile of Mood States

Instructions: Please describe **how you feel right now** by checking one box for each of the words listed below.

Feeling	Not At All	A Little	Moderately	Quite A Bit	Extremely
1 Friendly	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
2 Tense	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
3 Angry	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
4 Worn out	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
5 Unhappy	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
6 Clear-headed	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
7 Lively	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
8 Confused	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
9 Sorry for things done	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
10 Shaky	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
11 Listless	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
12 Peeved	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
13 Considerate	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
14 Sad	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
15 Active	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
16 On edge	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
17 Grouchy	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
18 Blue	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
19 Energetic	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
20 Panicky	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

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Participant's Initials:
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Center Number: ____ Participant Number: ____ Participant's Initials:
first middle last

Profile of Mood States (continued)

Feeling	Not At All	A Little	Moderately	Quite A Bit	Extremely
21 Hopeless	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
22 Relaxed	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
23 Unworthy	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
24 Spiteful	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
25 Sympathetic	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
26 Uneasy	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
27 Restless	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
28 Unable to concentrate	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
29 Fatigued	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
30 Helpful	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
31 Annoyed	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
32 Discouraged	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
33 Resentful	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
34 Nervous	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
35 Lonely	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
36 Miserable	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
37 Muddled	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
38 Cheerful	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
39 Bitter	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
40 Exhausted	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
41 Anxious	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
42 Ready to fight	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
43 Good-natured	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

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Profile of Mood States (continued)

Feeling	Not At All	A Little	Moderately	Quite A Bit	Extremely
44 Gloomy	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
45 Desperate	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
46 Sluggish	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
47 Rebellious	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
48 Helpless	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
49 Weary	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
50 Bewildered	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
51 Alert	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
52 Deceived	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
53 Furious	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
54 Efficient	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
55 Trusting	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
56 Full of pep	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
57 Bad-tempered	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
58 Worthless	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
59 Forgetful	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
60 Carefree	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
61 Terrified	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
62 Guilty	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
63 Vigorous	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
64 Uncertain about things	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
65 Bushed	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

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Date completed: ____/____/____ OR Not done → Specify reason (use codelist below): _____
day month year

Perceived Stress Scale (PSS)

Instructions: The questions in this scale ask you about your feelings and thoughts during the last month. In each case, please indicate how often you felt or thought a certain way. Please check only one answer for each question.

	Never	Almost Never	Some- times	Fairly Often	Very Often
1 In the last month, how often have you felt that you were unable to control the important things in your life?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
2 In the last month, how often have you felt confident about your ability to handle your personal problems?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
3 In the last month, how often have you felt that things were going your way?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
4 In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

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Date completed: ____/____/____ OR Not done → Specify reason (use codelist below): _____
day month year

Pittsburgh Sleep Quality Index (PSQI)

Instructions: The following questions relate to your usual sleep habits during the past month only. Your answers should indicate the most accurate reply for the majority of days and nights in the past month. Please answer all questions.

During the past month...

1 When have you usually gone to bed? _____ : _____
00:00 to 23:59

2 How long (in minutes) has it taken you to fall asleep each night? _____ minutes

3 When have you usually gotten up in the morning? _____ : _____
00:00 to 23:59

4 How many hours of actual sleep did you get at night?
(This may be different than the number of hours you spend in bed.) ____ . ____ hours

5 During the past month, how often have you had trouble sleeping because you... (check only one answer per question)	Not during the past month	Less than once a week	Once or twice a week	3 or more times a week
a Cannot get to sleep within 30 minutes	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
b Wake up in the middle of the night or early morning	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
c Have to get up to use the bathroom	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
d Cannot breathe comfortably	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
e Cough or snore loudly	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
f Feel too cold	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
g Feel too hot	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
h Have bad dreams	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
i Have pain	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
j Other reason(s), please describe, including how often you have had trouble sleeping because of this reason(s): _____	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
6 During the past month, how often have you taken medicine (prescribed or "over the counter") to help you sleep?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃

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Pittsburgh Sleep Quality Index (PSQI) (continued)

	Never	Once or twice	Once or twice each week	3 or more times each week
7 During the past month, how often have you had trouble staying awake while driving, eating meals, or engaging in social activity?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
	No problem at all	Only a very slight problem	Somewhat of a problem	A very big problem
8 During the past month, how much of a problem has it been for you to keep up enthusiasm to get things done?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
	Very good	Fairly good	Fairly bad	Very bad
9 During the past month, how would you rate your sleep quality overall?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃

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first middle last

Date completed: ____/____/____ OR Not done → Specify reason (use codelist below): _____
day month year

Derogatis Interview for Sexual Function (DISF-SR) (F) Female Version

Instruction: Below you will find a brief set of questions about your sexual activities. The questions are divided into different sections that ask about different aspects of your sexual experiences. One section asks about **sexual fantasies** or daydreams, while another inquires about the kinds of **sexual experiences** that you have. You are also asked about the nature of your **sexual arousal** and the quality of your **orgasm**. There are also a few other questions about different areas of your sexual relationship.

On some questions you are asked to respond in terms of a frequency scale, that is, "how often" do you perform the sexual activities asked about in that section. Some frequency scales go from "0 = not at all" to "8 = four or more times a day." Other frequency scales range from "0 = never" to "4 = always." In the case of other questions, you will be asked to respond in terms of a satisfaction scale. This type of scale tells how much you enjoyed, or were satisfied by the sexual activity being asked about. Some satisfaction scales range from "0 = could not be worse" to "8 = could not be better." Other satisfaction scales go from "0 = not at all satisfied," to "4 = extremely satisfied."

In every section of the inventory the scales required for that section are printed just above the questions so it will be easy to follow. Although it is brief, take your time with the inventory. **For each item, please check the scale number that best describes your personal experience.**

If you have any questions, please ask the person who gave you the inventory for help.

Section 1—Sexual Cognition/Fantasy

During the past 30 days or since the last time you filled out this inventory, how often have you had thoughts, dreams, or fantasies about:	Not at all	Less than 1 per month	1 or 2 per month	1 per week	2 or 3 per week	4 to 6 per week	1 per day	2 or 3 per day	4 or more per day
1.1 A sexually attractive person	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
1.2 Erotic parts of a man's body (e.g., face, shoulders, legs)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
1.3 Erotic or romantic situations	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
1.4 Caressing, touching, undressing, or foreplay	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
1.5 Sexual intercourse, oral sex, touching to orgasm	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈

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Derogatis Interview for Sexual Function (DISF-SR) (F) Female Version (continued)

Section 2—Sexual Arousal

During the past 30 days or since the last time you filled out this inventory, how often did you have the following experiences?	Not at all	Less than 1 per month	1 or 2 per month	1 per week	2 or 3 per week	4 to 6 per week	1 per day	2 or 3 per day	4 or more per day
2.1 Feel sexually aroused while alone	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
2.2 Actively seek sexual satisfaction	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
2.3 Feel sexually aroused with a partner	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
	Never	Rarely	Sometimes	Usually	Always				
2.4 Have normal lubrication with masturbation	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄				
2.5 Have normal lubrication throughout sexual relations	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄				

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Derogatis Interview for Sexual Function (DISF-SR) (F) Female Version (continued)

Section 3—Sexual Behavior/Experiences

During the past 30 days or since the last time you filled out the inventory, how often did you engage in the following sexual activities?	Not at all	Less than 1 per month	1 or 2 per month	1 per week	2 or 3 per week	4 to 6 per week	1 per day	2 or 3 per day	4 or more per day
3.1 Reading or viewing romantic or erotic books or stories	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
3.2 Masturbation	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
3.3 Casual kissing and petting	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
3.4 Sexual foreplay	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
3.5 Sexual intercourse, oral sex, etc.	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈

Section 4—Orgasm

During the past 30 days or since the last time you filled out this inventory, how <u>satisfied</u> have you been with the following?	Not at all	Slightly	Moderately	Highly	Extremely
4.1 Your ability to have an orgasm	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
4.2 The intensity of your orgasm	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
4.3 The ability to have multiple orgasms (if typical for you)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
4.4 Feelings of closeness and togetherness with your partner	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
4.5 Your sense of control (timing) of your orgasm	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
4.6 Feeling a sense of relaxation and well-being after orgasm	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

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Derogatis Interview for Sexual Function (DISF-SR) (F) Female Version (continued)

Section 5—Drive and Relationship

	Not at all	Less than 1 per month	1 or 2 per month	1 per week	2 or 3 per week	4 to 6 per week	1 per day	2 or 3 per day	4 or more per day
5.1 With the partner of your choice, what would be your ideal frequency of sexual intercourse?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
	Not at all	Slightly	Moderately	Highly	Extremely				
5.2 During this period, how interested have you been in sex?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄				
5.3 During this period, how satisfied have you been with your personal relationship with your sexual partner?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄				
	Could not be worse	Very poor	Poor	Somewhat inadequate	Adequate	Above average	Good	Very good	Could not be better
5.4 In general, what would represent the best description of the quality of your sexual functioning?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈

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Derogatis Interview for Sexual Function (DISF-SR) (M) Male Version

Instruction: Below you will find a brief set of questions about your sexual activities. The questions are divided into different sections that ask about different aspects of your sexual experiences. One section asks about **sexual fantasies** or daydreams, while another inquires about the kinds of **sexual experiences** that you have. You are also asked about the nature of your **sexual arousal** and the quality of your **orgasm**. There are also a few other questions about different areas of your sexual relationship.

On some questions you are asked to respond in terms of a frequency scale, that is, "how often" do you perform the sexual activities asked about in that section. Some frequency scales go from "0 = not at all" to "8 = four or more times a day." Other frequency scales range from "0 = never" to "4 = always." In the case of other questions, you will be asked to respond in terms of a satisfaction scale. This type of scale tells how much you enjoyed, or were satisfied by the sexual activity being asked about. Some satisfaction scales range from "0 = could not be worse" to "8 = could not be better." Other satisfaction scales go from "0 = not at all satisfied," to "4 = extremely satisfied."

In every section of the inventory the scales required for that section are printed just above the questions so it will be easy to follow. Although it is brief, take your time with the inventory. **For each item, please check the scale number that best describes your personal experience.**

If you have any questions, please ask the person who gave you the inventory for help.

Section 1—Sexual Cognition/Fantasy

During the past 30 days or since the last time you filled out this inventory, how often have you had thoughts, dreams, or fantasies about:	Not at all	Less than 1 per month	1 or 2 per month	1 per week	2 or 3 per week	4 to 6 per week	1 per day	2 or 3 per day	4 or more per day
1.1 A sexually attractive person	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
1.2 Erotic parts of a woman's body (e.g., face, genitals, legs)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
1.3 Erotic or romantic situations	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
1.4 Caressing, touching, undressing, or foreplay	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
1.5 Sexual intercourse, oral sex, touching to orgasm	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈

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Derogatis Interview for Sexual Function (DISF-SR) (M) Male Version (continued)

Section 2—Sexual Arousal

During the past 30 days or since the last time you filled out this inventory, how often did you have the following experiences?	Not at all	Less than 1 per month	1 or 2 per month	1 per week	2 or 3 per week	4 to 6 per week	1 per day	2 or 3 per day	4 or more per day
2.1 A full erection upon awakening	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
2.2 A full erection during a sexual fantasy or daydream	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
2.3 A full erection while looking at a sexually arousing person, movie, or picture	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
2.4 A full erection during masturbation	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
2.5 A full erection throughout the phases of a normal sexual response cycle, that is from undressing and foreplay through intercourse and orgasm	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈

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first middle last

Derogatis Interview for Sexual Function (DISF-SR) (M) Male Version (continued)

Section 3—Sexual Behavior/Experiences

During the past 30 days or since the last time you filled out the inventory, how often did you engage in the following sexual activities?	Not at all	Less than 1 per month	1 or 2 per month	1 per week	2 or 3 per week	4 to 6 per week	1 per day	2 or 3 per day	4 or more per day
3.1 Reading or viewing romantic or erotic books or stories	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4	<input type="checkbox"/> _5	<input type="checkbox"/> _6	<input type="checkbox"/> _7	<input type="checkbox"/> _8
3.2 Masturbation	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4	<input type="checkbox"/> _5	<input type="checkbox"/> _6	<input type="checkbox"/> _7	<input type="checkbox"/> _8
3.3 Casual kissing and petting	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4	<input type="checkbox"/> _5	<input type="checkbox"/> _6	<input type="checkbox"/> _7	<input type="checkbox"/> _8
3.4 Sexual foreplay	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4	<input type="checkbox"/> _5	<input type="checkbox"/> _6	<input type="checkbox"/> _7	<input type="checkbox"/> _8
3.5 Sexual intercourse, oral sex, etc.	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4	<input type="checkbox"/> _5	<input type="checkbox"/> _6	<input type="checkbox"/> _7	<input type="checkbox"/> _8

Section 4—Orgasm

During the past 30 days or since the last time you filled out this inventory, how <u>satisfied</u> have you been with the following?	Not at all	Slightly	Moderately	Highly	Extremely
4.1 Your ability to have an orgasm	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
4.2 The intensity of your orgasm	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
4.3 The length or duration of your orgasm	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
4.4 The amount of seminal liquid that you ejaculate	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
4.5 Your sense of control (timing) of your orgasm	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
4.6 Feeling a sense of relaxation and well-being after orgasm	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Derogatis Interview for Sexual Function (DISF-SR) (M) Male Version (continued)

Section 5—Drive and Relationship

	Not at all	Less than 1 per month	1 or 2 per month	1 per week	2 or 3 per week	4 to 6 per week	1 per day	2 or 3 per day	4 or more per day
5.1 With the partner of your choice, what would be your ideal frequency of sexual intercourse?	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4	<input type="checkbox"/> _5	<input type="checkbox"/> _6	<input type="checkbox"/> _7	<input type="checkbox"/> _8
	Not at all	Slightly	Moderately	Highly	Extremely				
5.2 During this period, how interested have you been in sex?	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4				
5.3 During this period, how satisfied have you been with your personal relationship with your sexual partner?	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4				
	Could not be worse	Very poor	Poor	Somewhat inadequate	Adequate	Above average	Good	Very good	Could not be better
5.4 In general, what would represent the best description of the quality of your sexual functioning?	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4	<input type="checkbox"/> _5	<input type="checkbox"/> _6	<input type="checkbox"/> _7	<input type="checkbox"/> _8

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Participant's Initials: _____
first middle last

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Date completed: ____/____/____ OR Not done → Specify reason (use codelist below): _____
day month year

Food Cravings Questionnaire—State (FCQ—S)

Below is a list of comments made by people about their eating habits. Please check one answer for each comment that indicates how much you agree with the comment **right now, at this very moment**. Notice that some questions refer to foods in general while others refer to one or more specific foods. Please respond to each item as honestly as possible.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1 I have an intense desire to eat [one or more specific foods].	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
2 I'm craving [one or more specific foods].	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
3 I have an urge for [one or more specific foods]	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
4 Eating [one or more specific foods] would make things seem just perfect.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
5 If I were to eat what I am craving, I am sure my mood would improve.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
6 Eating [one or more specific foods] would feel wonderful.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
7 If I ate something, I wouldn't feel so sluggish and lethargic.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
8 Satisfying my craving would make me feel less grouchy and irritable.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
9 I would feel more alert if I could satisfy my craving.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
10 If I had [one or more specific foods], I could not stop eating it.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
11 My desire to eat [one or more specific foods] seems overpowering.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
12 I know I'm going to keep on thinking about [one or more specific foods] until I actually have it.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
13 I am hungry.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
14 If I ate right now, my stomach wouldn't feel as empty.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
15 I feel weak because of not eating.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

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day month year

Food Craving Inventory (FCI-II)

For each of the foods listed below, please check the appropriate box.

Note: A craving is defined as an intense desire to consume a particular food or food type that is difficult to resist.

Over the past month, how often have you experienced a craving for...	Never	Rarely (once or twice)	Sometimes	Often	Always/Almost Every Day
1 Cake	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
2 Pizza	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
3 Fried chicken	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
4 Gravy	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
5 Sandwich bread	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
6 Sausage	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
7 French fries	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
8 Cinnamon rolls	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
9 Rice	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
10 Hot dog	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
11 Hamburger	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
12 Biscuits	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
13 Ice cream	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
14 Pasta	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
15 Fried fish	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
16 Cookies	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
17 Chocolate	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
18 Pancakes or waffles	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
19 Corn bread	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
20 Chips	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
21 Rolls	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
22 Cereal	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
23 Donuts	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
24 Candy	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
25 Brownies	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
26 Bacon	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
27 Steak	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
28 Baked potato	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

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Date completed: day ____ / month ____ / year ____ OR Not done → Specify reason (use codelist below): _____

Eating Inventory

- | | | | |
|----|--|--|---|
| 1 | When I smell a sizzling steak or see a juicy piece of meat, I find it very difficult to keep from eating, even if I have just finished a meal. | <input type="checkbox"/> ₁ True | <input type="checkbox"/> ₀ False |
| 2 | I usually eat too much at social occasions, like parties and picnics. | <input type="checkbox"/> ₁ True | <input type="checkbox"/> ₀ False |
| 3 | I am usually so hungry that I eat more than three times a day. | <input type="checkbox"/> ₁ True | <input type="checkbox"/> ₀ False |
| 4 | When I have eaten my quota of calories, I am usually good about not eating anymore. | <input type="checkbox"/> ₁ True | <input type="checkbox"/> ₀ False |
| 5 | Dieting is so hard for me because I just get too hungry. | <input type="checkbox"/> ₁ True | <input type="checkbox"/> ₀ False |
| 6 | I deliberately take small helpings as a means of controlling my weight. | <input type="checkbox"/> ₁ True | <input type="checkbox"/> ₀ False |
| 7 | Sometimes things just taste so good that I keep on eating even when I am no longer hungry. | <input type="checkbox"/> ₁ True | <input type="checkbox"/> ₀ False |
| 8 | Since I am often hungry, I sometimes wish that while I am eating, an expert would tell me that I have had enough or that I can have something more to eat. | <input type="checkbox"/> ₁ True | <input type="checkbox"/> ₀ False |
| 9 | When I feel anxious, I find myself eating. | <input type="checkbox"/> ₁ True | <input type="checkbox"/> ₀ False |
| 10 | Life is too short to worry about dieting. | <input type="checkbox"/> ₁ True | <input type="checkbox"/> ₀ False |
| 11 | Since my weight goes up and down, I have gone on reducing diets more than once. | <input type="checkbox"/> ₁ True | <input type="checkbox"/> ₀ False |
| 12 | I often feel so hungry that I just have to eat something. | <input type="checkbox"/> ₁ True | <input type="checkbox"/> ₀ False |
| 13 | When I am with someone who is overeating, I usually overeat too. | <input type="checkbox"/> ₁ True | <input type="checkbox"/> ₀ False |
| 14 | I have a pretty good idea of the number of calories in common food. | <input type="checkbox"/> ₁ True | <input type="checkbox"/> ₀ False |
| 15 | Sometimes when I start eating, I just can't seem to stop. | <input type="checkbox"/> ₁ True | <input type="checkbox"/> ₀ False |
| 16 | It is not difficult for me to leave something on my plate. | <input type="checkbox"/> ₁ True | <input type="checkbox"/> ₀ False |
| 17 | At certain times of the day, I get hungry because I have gotten used to eating then. | <input type="checkbox"/> ₁ True | <input type="checkbox"/> ₀ False |
| 18 | While on a diet, if I eat food that is not allowed, I consciously eat less for a period of time to make up for it. | <input type="checkbox"/> ₁ True | <input type="checkbox"/> ₀ False |

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Eating Inventory (continued)

- 19** Being with someone who is eating often makes me hungry to eat also. ₁ True ₀ False
- 20** When I feel blue, I often overeat. ₁ True ₀ False
- 21** I enjoy eating too much to spoil it by counting calories or watching my weight. ₁ True ₀ False
- 22** When I see a real delicacy, I often get so hungry that I have to eat right away. ₁ True ₀ False
- 23** I often stop eating when I am not really full as a conscious means of limiting the amount I eat. ₁ True ₀ False
- 24** I get so hungry that my stomach often seems like a bottomless pit. ₁ True ₀ False
- 25** My weight has hardly changed at all in the last ten years. ₁ True ₀ False
- 26** I am always hungry so it is hard for me to stop eating before I finish the food on my plate. ₁ True ₀ False
- 27** When I feel lonely, I console myself by eating. ₁ True ₀ False
- 28** I consciously hold back at meals in order not to gain weight. ₁ True ₀ False
- 29** I sometimes get very hungry late in the evening or at night. ₁ True ₀ False
- 30** I eat anything I want, any time I want. ₁ True ₀ False
- 31** Without even thinking about it, I take a long time to eat. ₁ True ₀ False
- 32** I count calories as a conscious means of controlling my weight. ₁ True ₀ False
- 33** I do not eat some foods because they make me fat. ₁ True ₀ False
- 34** I am always hungry enough to eat at any time. ₁ True ₀ False
- 35** I pay a great deal of attention to changes in my figure. ₁ True ₀ False
- 36** While on a diet, if I eat a food that is not allowed, I often splurge and eat other high calorie foods. ₁ True ₀ False

Participant's Initials: first middle last ____

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Eating Inventory (continued)

Please check one answer that is most appropriate to you for each question below.

37	How often are you dieting in a conscious effort to control your weight?	<input type="checkbox"/> ₁ Rarely	<input type="checkbox"/> ₂ Sometimes	<input type="checkbox"/> ₃ Usually	<input type="checkbox"/> ₄ Always		
38	Would a weight fluctuation of 5 pounds affect the way you live your life?	<input type="checkbox"/> ₁ Rarely	<input type="checkbox"/> ₂ Sometimes	<input type="checkbox"/> ₃ Usually	<input type="checkbox"/> ₄ Always		
39	How often do you feel hungry?	<input type="checkbox"/> ₁ Rarely	<input type="checkbox"/> ₂ Sometimes	<input type="checkbox"/> ₃ Usually	<input type="checkbox"/> ₄ Always		
40	Do your feelings of guilt about overeating help you to control your food intake?	<input type="checkbox"/> ₁ Rarely	<input type="checkbox"/> ₂ Sometimes	<input type="checkbox"/> ₃ Usually	<input type="checkbox"/> ₄ Always		
41	How difficult would it be for you to stop eating halfway through dinner and not eat for the next four hours?	<input type="checkbox"/> ₁ Easy	<input type="checkbox"/> ₂ Slightly difficult	<input type="checkbox"/> ₃ Moderately difficult	<input type="checkbox"/> ₄ Very difficult		
42	How conscious are you of what you are eating?	<input type="checkbox"/> ₁ Not at all	<input type="checkbox"/> ₂ Slightly	<input type="checkbox"/> ₃ Moderately	<input type="checkbox"/> ₄ Extremely		
43	How frequently do you avoid "stocking up" on tempting foods?	<input type="checkbox"/> ₁ Almost never	<input type="checkbox"/> ₂ Seldom	<input type="checkbox"/> ₃ Usually	<input type="checkbox"/> ₄ Almost always		
44	How likely are you to shop for low calorie foods?	<input type="checkbox"/> ₁ Unlikely	<input type="checkbox"/> ₂ Slightly likely	<input type="checkbox"/> ₃ Moderately likely	<input type="checkbox"/> ₄ Very likely		
45	Do you eat sensibly in front of others and splurge alone?	<input type="checkbox"/> ₁ Never	<input type="checkbox"/> ₂ Rarely	<input type="checkbox"/> ₃ Often	<input type="checkbox"/> ₄ Always		
46	How likely are you to consciously eat slowly in order to cut down on how much you eat?	<input type="checkbox"/> ₁ Unlikely	<input type="checkbox"/> ₂ Slightly likely	<input type="checkbox"/> ₃ Moderately likely	<input type="checkbox"/> ₄ Very likely		
47	How frequently do you skip dessert because you are no longer hungry?	<input type="checkbox"/> ₁ Almost never	<input type="checkbox"/> ₂ Seldom	<input type="checkbox"/> ₃ At least once a week	<input type="checkbox"/> ₄ Almost every day		
48	How likely are you to consciously eat less than you want?	<input type="checkbox"/> ₁ Unlikely	<input type="checkbox"/> ₂ Slightly likely	<input type="checkbox"/> ₃ Moderately likely	<input type="checkbox"/> ₄ Very likely		
49	Do you go on eating binges though you are not hungry?	<input type="checkbox"/> ₁ Never	<input type="checkbox"/> ₂ Rarely	<input type="checkbox"/> ₃ Sometimes	<input type="checkbox"/> ₄ At least once a week		
50	To what extent does this statement describe your eating behavior? "I start dieting in the morning, but because of any number of things that happen during the day, by evening I have given up and eat what I want, promising myself to start dieting again tomorrow."	<input type="checkbox"/> ₁ Not like me	<input type="checkbox"/> ₂ Little like me	<input type="checkbox"/> ₃ Pretty good description of me	<input type="checkbox"/> ₄ Describes me perfectly		
51	On a scale of 0 to 5, where 0 means no restraint in eating (eating whatever you want, whenever you want it) and 5 means total restraint (constantly limiting food intake and never "giving in"), what number would you give yourself?	<input type="checkbox"/> ₀ Eat whatever you want, whenever you want it	<input type="checkbox"/> ₁ Usually eat whatever you want, whenever you want it	<input type="checkbox"/> ₂ Often eat whatever you want, whenever you want it	<input type="checkbox"/> ₃ Often limit food intake, but often "give in"	<input type="checkbox"/> ₄ Usually limit food intake, rarely "give in"	<input type="checkbox"/> ₅ Constantly limiting food intake, never "giving in"

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day month year

Weight Efficacy Lifestyle Questionnaire (WEL)

This form describes some typical eating situations. Everyone has situations which make it very hard for them to keep their weight down. The following are a number of situations relating to eating patterns and attitudes. This form will help you to identify the eating situations which you find the hardest to manage.

Read each situation listed below and decide how confident (or certain) you are that you will be able to resist eating in each of the difficult situations. In other words, pretend that you are in the eating situation right now. On a scale from 0 (not confident) to 9 (very confident), choose ONE number that reflects how confident you feel now about being able to **successfully resist** the desire to eat. Check this number for each item.

I am confident that:	Not confident at all that you can resist the desire to eat					Very confident that you can resist the desire to eat				
	0	1	2	3	4	5	6	7	8	9
1 I can resist eating when I am anxious (nervous).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 I can control my eating on the weekends.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 I can resist eating even when I have to say "no" to others.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 I can resist eating when I feel physically run down.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 I can resist eating when I am watching TV.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 I can resist eating when I am depressed (or down).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7 I can resist eating when there are many different kinds of food available.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8 I can resist eating even when I feel it is impolite to refuse a second helping.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9 I can resist eating even when I have a headache.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Participant's Initials: ____
first middle last

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Weight Efficacy Lifestyle Questionnaire (WEL) (continued)

I am confident that:	Not confident at all that you can resist the desire to eat					Very confident that you can resist the desire to eat				
	0	1	2	3	4	5	6	7	8	9
10 I can resist eating when I am reading.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 I can resist eating when I am angry (or irritable).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12 I can resist eating even when I am at a party.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13 I can resist eating even when others are pressuring me to eat.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14 I can resist eating when I am in pain.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15 I can resist eating just before going to bed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16 I can resist eating when I have experienced failure.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17 I can resist eating when high-calorie foods are available.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18 I can resist eating even when I think others will be upset if I don't eat.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19 I can resist eating when I feel uncomfortable.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20 I can resist eating when I am happy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Participant's Initials: _____
first middle last

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Date completed: ____/____/____ OR Not done → Specify reason (use codelist below): _____
day month year

Multiaxial Assessment of Eating Disorder Symptoms (MAEDS)

Instructions: Using the scale shown, please rate the following items on a scale from 1 to 7. Please answer as truthfully as possible.

	Never	Very Rarely	Rarely	Sometimes	Often	Very Often	Always
1 Fasting is a good way to lose weight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
2 My sleep isn't as good as it used to be.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
3 I avoid eating for as long as I can.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
4 Certain foods are "forbidden" for me to eat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
5 I can't keep certain foods in my house because I will binge on them.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
6 I can easily make myself vomit.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
7 I can feel that being fat is terrible.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
8 I avoid greasy foods.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
9 It's okay to binge and purge once in a while.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
10 I don't eat certain foods.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
11 I think I am a good person.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
12 My eating is normal.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
13 I can't seem to concentrate lately.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
14 I try to diet by fasting.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
15 I vomit to control my weight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
16 Lately nothing seems enjoyable anymore.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
17 Laxatives help keep you slim.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
18 I don't eat red meat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
19 I eat so rapidly I can't even taste my food.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Participant's Initials: _____
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Multiaxial Assessment of Eating Disorder Symptoms (MAEDS) (continued)

	Never	Very Rarely	Rarely	Some-times	Often	Very Often	Always
20 I do everything I can to avoid being overweight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
21 When I feel bloated, I must do something to rid myself of that feeling.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
22 I overeat too frequently.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
23 It's okay to be overweight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
24 Recently I have felt that I am a worthless person.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
25 I would be very upset if I gained 2 pounds.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
26 I crave sweets and carbohydrates.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
27 I lose control when I eat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
28 Being fat would be terrible.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
29 I have thought seriously about suicide lately.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
30 I don't have any energy anymore.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
31 I eat small portions to control my weight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
32 I eat 3 meals a day.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
33 Lately I have been easily irritated.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
34 Some foods should be totally avoided.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
35 I use laxatives to control my weight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
36 I am terrified by the thought of being overweight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
37 Purging is a good way to lose weight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
38 I avoid fatty foods.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇

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Multiaxial Assessment of Eating Disorder Symptoms (MAEDS) (continued)

	Never	Very Rarely	Rarely	Some-times	Often	Very Often	Always
39 Recently I have felt pretty blue.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
40 I am obsessed with becoming overweight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
41 I don't eat fried foods.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
42 I skip meals.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
43 Fat people are unhappy.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
44 People are too concerned with the way I eat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
45 I feel good when I skip meals.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
46 I avoid foods with sugar.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
47 I hate it when I feel fat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
48 I am too fat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
49 I eat until I am completely stuffed.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
50 I hate to eat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
51 I feel guilty about a lot of things these days.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
52 I'm very careful of what I eat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
53 I can "hold off" and not eat even if I am hungry.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
54 I eat even when I am not hungry.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
55 Fat people are disgusting.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
56 I wouldn't mind gaining a few pounds.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇

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Date completed: ____/____/____ OR Not done → Specify reason (use codelist below): _____
day month year

Body Shape Questionnaire (BSQ)

We would like to know how you have been feeling about your appearance over the **past four weeks**. Please read each question and check the box for the appropriate choice. Please answer all the questions.

Over the Past Four Weeks...	Never	Rarely	Sometimes	Often	Very Often	Always
1 Has feeling bored made you brood about your shape?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
2 Have you been so worried about your shape that you have been feeling that you ought to diet?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
3 Have you thought that your thighs, hips, or bottom are too large for the rest of you?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
4 Have you been afraid that you might become fat (or fatter)?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
5 Have you worried about your flesh not being firm enough?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
6 Has feeling full (e.g., after eating a large meal) made you feel fat?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
7 Have you felt so bad about your shape that you have cried?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
8 Have you avoided running because your flesh might wobble?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
9 Has being with thin women/men made you feel self-conscious about your shape?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
10 Have you worried about your thighs spreading out when sitting down?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
11 Has eating even a small amount of food made you feel fat?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
12 Have you noticed the shape of other women/men and felt that your own shape compared unfavorably?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
13 Has thinking about your shape interfered with your ability to concentrate (e.g., while watching TV, reading, listening to conversations)?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
14 Has being naked, such as when taking a bath, made you feel fat?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
15 Have you avoided wearing clothes which make you particularly aware of the shape of your body?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
16 Have you imagined cutting off fleshy areas of your body?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

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Body Shape Questionnaire (BSQ) (continued)

Over the Past Four Weeks...	Never	Rarely	Some- times	Often	Very Often	Always
17 Has eating sweets, cakes or other high calorie food made you feel fat?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
18 Have you not gone out on social occasions (e.g., parties) because you have felt bad about your shape?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
19 Have you felt excessively large and rounded?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
20 Have you felt ashamed of your body?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
21 Has worry about your shape made you diet?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
22 Have you felt happiest about your shape when your stomach has been empty?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
23 Have you thought that you are the shape you are because you lack self-control?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
24 Have you worried about other people seeing rolls of flesh around your waist or stomach?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
25 Have you felt that it is not fair that other women/men are thinner than you?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
26 Have you vomited in order to feel thinner?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
27 When in company, have you worried about taking up too much room (e.g., sitting on a sofa or bus seat)?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
28 Have you worried about your flesh being dimply?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
29 Has seeing your reflection (e.g., in a mirror or shop window) made you feel bad about your shape?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
30 Have you pinched areas of your body to see how much fat is there?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
31 Have you avoided situations where people could see your body (e.g., communal changing rooms or swimming pools)?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
32 Have you taken laxatives in order to feel thinner?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
33 Have you been particularly self-conscious about your shape when in the company of other people?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
34 Has worry about your shape made you feel you ought to exercise?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆

Participant's Initials: _____
first middle last

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Center Number: ____ Participant Number: ____ Participant's Initials: first middle last

Handgrip Strength

Date and time of assessment: ____/____/____ 00:00 to 23:59
day month year

Staff initials: first middle last

OR Not done → Specify reason (use codelist below): ____

1 Dynamometer handle position: _____

2 Dominant hand (check only one): ₁ Left ₂ Right ₃ Ambidextrous

3 Handgrip strength:

Handgrip Strength	Zero Meter Check	Right Hand	Zero Meter Check	Left Hand
Test 1—peak force	<input type="checkbox"/> ₀	_____ kg	<input type="checkbox"/> ₀	_____ kg
Test 2—peak force	<input type="checkbox"/> ₀	_____ kg	<input type="checkbox"/> ₀	_____ kg
Test 3—peak force	<input type="checkbox"/> ₀	_____ kg	<input type="checkbox"/> ₀	_____ kg

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Isometric/Isokinetic Knee Extension and Flexion

Date and time of assessment: ____/____/____ :____:____
day month year 00:00 to 23:59

Staff initials: _____
first middle last

OR Not done → Specify reason (use codelist below): _____

- 1** Recent injury or pain—right knee? ₀ No ₁ Yes
- 2** Recent injury or pain—left knee? ₀ No ₁ Yes
- 3** Specify machine used (PBRC only): ₀ Cybex ₁ Biolex

All values corrected for gravity effect torque		Right Leg	Left Leg	If Not Done, Specify Reason (Use codelist below)
3 60°/sec knee extension	peak torque	_____ N.m	_____ N.m	_____
	total work	_____ N.m	_____ N.m	
	average power	_____ watts	_____ watts	
4 60°/sec knee flexion	peak torque	_____ N.m	_____ N.m	_____
	total work	_____ N.m	_____ N.m	
	average power	_____ watts	_____ watts	
5 180°/sec knee extension	peak torque	_____ N.m	_____ N.m	_____
	total work	_____ N.m	_____ N.m	
	average power	_____ watts	_____ watts	
	work fatigue index	_____ %	_____ %	
6 180°/sec knee flexion	peak torque	_____ N.m	_____ N.m	_____
	total work	_____ N.m	_____ N.m	
	average power	_____ watts	_____ watts	
	work fatigue index	_____ %	_____ %	
7 Isometric knee extension: trial 1	peak torque	_____ N.m	_____ N.m	_____
	trial 2 peak torque	_____ N.m	_____ N.m	
	trial 3 peak torque	_____ N.m	_____ N.m	
8 Isometric knee flexion: trial 1	peak torque	_____ N.m	_____ N.m	_____
	trial 2 peak torque	_____ N.m	_____ N.m	
	trial 3 peak torque	_____ N.m	_____ N.m	

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: ____ Participant Number: ____ Participant's Initials: first middle last ____

Clinic Weight

Weight date and time: ____/____/____ : ____
day month year 00:00 to 23:59

Staff initials: ____
first middle last

OR Not done → Specify reason (use codelist below): ____

Clinic weight (if the two measurements are more than 0.1 kg apart, measure weight a third time):

Weight 1: ____ . ____ kg

Weight 2: ____ . ____ kg

Weight 3: ____ . ____ kg

Weight of gown: ____ . ____ kg

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Seven-Day Physical Activity Recall (PAR)

Today's date: ___/___/___ Day (check only one): Mon Tues Wed Thurs Fri Sat Sun **OR Not done** → Specify reason (use code/list below): _____

1 Were you employed in the last seven days? No → Skip to question 3 Yes
 Interviewer initials: _____
first middle last

2 If Yes: Which days (check all that apply)?
 Mon Tues Wed Thurs Fri Sat Sun

3 Which days do you consider your weekend, or non-work, days?
 Mon Tues Wed Thurs Fri Sat Sun

Day #	Day of Week	Date ____/____/____ <small>day month year</small>	Sleep Time		Work Time			Morning (in minutes)			Afternoon (in minutes)			Evening (in minutes)	
			In Bed	Up	Start	Stop	Mod.	Hard	Very Hard	Mod.	Hard	Very Hard	Mod.	Hard	Very Hard
7	(yester-day)	____/____/____ <small>day month year</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>
6		____/____/____ <small>day month year</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>
5		____/____/____ <small>day month year</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>
4		____/____/____ <small>day month year</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>
3		____/____/____ <small>day month year</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>
2		____/____/____ <small>day month year</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>
1	(1 week ago)	____/____/____ <small>day month year</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: ____ Participant Number: ____ Participant's Initials: first middle last ____

Seven-Day Physical Activity Recall (PAR) (continued)

4 Compared to your physical activity over the past three months, was last week's physical activity more, less, or about the same (check only one)?

- ₁ More
₂ Less
₃ About the same

Interviewer: Please answer questions below and note any comments on interview.

5 Were there any problems with the Seven-Day PAR interview?

- ₀ No
₁ Yes

6 Do you think this was a valid Seven-Day PAR interview?

- ₀ No
₁ Yes

7 Were there any activities reported by the participant that you don't know how to classify?

- ₀ No
₁ Yes

Center Number: ____ Participant Number: ____ Participant's Initials: first middle last ____

6-Day Food Record

Complete below OR Not done → Specify reason (use Codelist below): _____ Staff initials: first middle last ____

			Replacement Values		
Day of DLW	Date of Record	Record Quality (check only one)	Day of DLW	Date of Record	Record Quality (check only one)
1	____/____/____ <small>day month year</small>	<input type="checkbox"/> ₁ Reliable <input type="checkbox"/> ₂ Unreliable <input type="checkbox"/> ₃ Missing	8	____/____/____ <small>day month year</small>	<input type="checkbox"/> ₁ Reliable <input type="checkbox"/> ₂ Unreliable <input type="checkbox"/> ₃ Missing
2	____/____/____ <small>day month year</small>	<input type="checkbox"/> ₁ Reliable <input type="checkbox"/> ₂ Unreliable <input type="checkbox"/> ₃ Missing	9	____/____/____ <small>day month year</small>	<input type="checkbox"/> ₁ Reliable <input type="checkbox"/> ₂ Unreliable <input type="checkbox"/> ₃ Missing
3	____/____/____ <small>day month year</small>	<input type="checkbox"/> ₁ Reliable <input type="checkbox"/> ₂ Unreliable <input type="checkbox"/> ₃ Missing	10	____/____/____ <small>day month year</small>	<input type="checkbox"/> ₁ Reliable <input type="checkbox"/> ₂ Unreliable <input type="checkbox"/> ₃ Missing
4	____/____/____ <small>day month year</small>	<input type="checkbox"/> ₁ Reliable <input type="checkbox"/> ₂ Unreliable <input type="checkbox"/> ₃ Missing	11	____/____/____ <small>day month year</small>	<input type="checkbox"/> ₁ Reliable <input type="checkbox"/> ₂ Unreliable <input type="checkbox"/> ₃ Missing
5	____/____/____ <small>day month year</small>	<input type="checkbox"/> ₁ Reliable <input type="checkbox"/> ₂ Unreliable <input type="checkbox"/> ₃ Missing	12	____/____/____ <small>day month year</small>	<input type="checkbox"/> ₁ Reliable <input type="checkbox"/> ₂ Unreliable <input type="checkbox"/> ₃ Missing
6	____/____/____ <small>day month year</small>	<input type="checkbox"/> ₁ Reliable <input type="checkbox"/> ₂ Unreliable <input type="checkbox"/> ₃ Missing	13	____/____/____ <small>day month year</small>	<input type="checkbox"/> ₁ Reliable <input type="checkbox"/> ₂ Unreliable <input type="checkbox"/> ₃ Missing

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

VO₂ Max

1 Date and time of test: ____/____/____ year ____:____ 00:00 to 23:59 **Staff initials:** _____
day month year first middle last

OR Not done → Specify reason (use codelist below): _____

2 At what time was the participant's last meal/snack eaten? ____:____
00:00 to 23:59

3 Rest ECG: Rhythm (check only one): ₁ Sinus ₂ Atrial fibrillation ₉₈ Other
Ventricular conduction (check only one): ₁ Normal ₂ LBBB ₃ RBBB

4 Heart rate (HR) data: Resting heart rate: _____ bpm
 Age-predicted heart rate: _____ bpm
 Heart rate (max): _____ bpm

5 Reason(s) for termination of testing (check all that apply):

- Symptom limited (dyspnea, fatigue)
- Angina/ischemia → Complete all that apply: HR when true cardiac angina occurred: _____ bpm OR ₉₆ NA
 HR when ischemic ECG changes occurred: _____ bpm OR ₉₆ NA
- Serious arrhythmias (VT or SVT)
- Changes in blood pressure
- Ventricular ischemia (schedule stress image study, complete ventricular episode report)
- Orthopedic/extremity complaints (pains/cramps)
- Other (specify): _____

6 Did frequent ventricular ectopy occur (e.g., ≥ 7 PVCs/min, bi/tri-geminy, NSVT [≥ 3 beats])?

- ₀ No
- ₁ Yes → If Yes: When did it occur (check all that apply)? During exercise During recovery

7 Peak VO₂: _____ mL/kg/min _____ L/min

8 Did the participant meet at least 2 of the 3 VO₂ max criteria (see box, right)?

- ₀ No
- ₁ Yes → If Yes: VO₂ max: _____ mL/kg/min _____ L/min

a Achieve a plateau in VO₂ (change ≤ 150 mL between the final two stages)
 b RER ≥ 1.1
 c HR max ± 5 bpm of age-predicted maximum

9 Exercise time: ____:____
minutes seconds

10 Blood pressure at VO₂ peak/VO₂ max: ____/____ mm Hg
systolic diastolic

11 Borg RPE score at VO₂ peak/VO₂ max: _____ (6-20)

12 Peak RER: _____

13 VE at VO₂ peak/VO₂ max: _____ L/min

14 VE/VO₂ at VO₂ peak/VO₂ max _____ L/min

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: ____ Participant Number: ____ Participant's Initials: ____
first middle last

Core Temperature			
Staff Initials	Provide Date of Sample Collection/Procedure	Time of Sample Collection/Procedure	If Not Done, Reason <small>(Use codelist below)</small>
<small>first middle last</small>	Start Date: ____ / ____ / ____ <small>day month year</small>	Start Time ____ : ____ <small>00:00 to 23:59</small>	_____
	Stop Date: ____ / ____ / ____ <small>day month year</small>	Stop Time ____ : ____ <small>00:00 to 23:59</small>	

Inpatient Admission and Discharge	
1 Inpatient admission date and time:	____ / ____ / ____ : ____ <small>day month year 00:00 to 23:59</small>
2 Inpatient discharge date and time:	____ / ____ / ____ : ____ <small>day month year 00:00 to 23:59</small>

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Delayed-type Hypersensitivity (DTH)

1 Was the DTH worksheet completed?

₀ No

₁ Yes → If Yes: Were any Exclusion criteria met? ₀ No → Proceed with test

₁ Yes → STOP. Do not administer test.

2 Date of injection: _____ / _____ / _____ OR Not done → Specify reason (use codelist below): _____
day month year

3 Injection by (initials): _____
first middle last

4 Arm injected: ₁ Right ₂ Left

5 DTH results:

Note: For each reaction, measure two diameters in millimeters (mm). The first diameter is called the maximum diameter because the induration may not be in the shape of a circle. If the induration is an oval shape, first measure the long diameter and then the diameter perpendicular to it. Do not measure erythema. Reaction is considered positive if the average diameter is equal to or greater than 5 mm.

A = Largest diameter

B = Second diameter perpendicular to A

Antigen	24 Hour (@ Visit 4)			48 Hour (@ Visit 5)		
	A (diameter)	B (diameter)	Read By:	A (diameter)	B (diameter)	Read By:
1 Normal saline	_____ mm	_____ mm	 <small>first middle last</small> (initials)	_____ mm	_____ mm	 <small>first middle last</small> (initials)
2 Tetanus toxoid (TT)	_____ mm	_____ mm		_____ mm	_____ mm	
3 Candida	_____ mm	_____ mm		_____ mm	_____ mm	
4 Trichophyton	_____ mm	_____ mm		_____ mm	_____ mm	

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Clinic Weight

Weight date and time: _____/_____/_____ : _____
day month year 00:00 to 23:59

Staff initials: _____
first middle last

OR Not done → Specify reason (use codelist below): _____

Clinic weight (if the two measurements are more than 0.1 kg apart, measure weight a third time):

Weight 1: _____ . _____ kg

Weight 2: _____ . _____ kg

Weight 3: _____ . _____ kg

Weight of gown: _____ . _____ kg

Outcomes Labs

Date and time of last meal: _____/_____/_____ : _____
day month year 00:00 to 23:59

Date and time sample collection started: _____/_____/_____ : _____
day month year 00:00 to 23:59

Sample	Sample Complete?	If Not Done, Reason (Use codelist below)	Staff Initials
Catecholamines	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	_____	_____ <small>first middle last</small>
Blood	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	_____	_____ <small>first middle last</small>
Oral glucose tolerance test (OGTT)	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	_____	_____ <small>first middle last</small>

If a sample is not obtained, indicate with a Not Done.

24-hour Urine Collection

Total Volume Collected	Date of Sample Collection	Time of Sample Collection	If Not Done, Reason (Use codelist below)	Staff Initials
_____ mL	<p>Start Date:</p> <p>_____/_____/_____</p> <p><small>day month year</small></p> <p>Stop Date:</p> <p>_____/_____/_____</p> <p><small>day month year</small></p>	<p>Start Time:</p> <p>_____:_____</p> <p><small>00:00 to 23:59</small></p> <p>Stop Time:</p> <p>_____:_____</p> <p><small>00:00 to 23:59</small></p>	_____	_____ <small>first middle last</small>

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

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Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Sex Hormone

If Not Done → Specify reason (use codelist below): _____

Contraception method (females only):

None OR Check all that apply:

Oral contraceptive → Specify: _____

Record on Concomitant Medications page

Other → Specify (e.g., barrier, IUD): _____

Day 1	Date	Time	If Not Done, Reason (use codelist)	Staff Initials
Day 1 of menses (females only)				
Date and time of last meal (males only)	____/____/____ <small>day month year</small>	____:____ <small>00:00 to 23:59</small>		
Hormone level blood draw 1 (males only)	____/____/____ <small>day month year</small>	____:____ <small>00:00 to 23:59</small>	_____	____ <small>first middle last</small>
Hormone level blood draw 2 (females only) <i>Progesterone level</i>				
Day 2	Date	Time	If Not Done, Reason (use codelist)	Staff Initials
Date and time of last meal				
Hormone level blood draw 3 (females only) <i>Progesterone level</i>				

Metabolic Rate

Sample	Date of Collection	If Not Done, Reason (Use codelist below)	Staff Initials
Resting Metabolic Rate (RMR)—Visit 4	____/____/____ <small>day month year</small>	_____	____ <small>first middle last</small>
Cart ID	<input type="checkbox"/> Tufts-003 (623-002) <input type="checkbox"/> WASH U-001 (623-003) <input type="checkbox"/> PBRC-016 (623-005) <input type="checkbox"/> Tufts-006 (623-006) <input type="checkbox"/> WASH U-002 (623-004) <input type="checkbox"/> PBRC-017 (623-001)		

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Seven-Day Physical Activity Recall (PAR)

Today's date: ___/___/___ Day (check only one): Mon Tues Wed Thurs Fri Sat Sun OR Not done → Specify reason (use code/list below): _____

1 Were you employed in the last seven days? No → Skip to question 3 Yes

2 If Yes: Which days (check all that apply)?
 Mon Tues Wed Thurs Fri Sat Sun

3 Which days do you consider your weekend, or non-work, days?
 Mon Tues Wed Thurs Fri Sat Sun

Interviewer initials: _____
first middle last

Day #	Date	Sleep Time		Work Time			Morning (in minutes)			Afternoon (in minutes)			Evening (in minutes)		
		In Bed	Up	Start	Stop	Mod.	Hard	Very Hard	Mod.	Hard	Very Hard	Mod.	Hard	Very Hard	
7 <small>(yester- day)</small>	___/___/___ <small>day month year</small>	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59										
6	___/___/___ <small>day month year</small>	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59										
5	___/___/___ <small>day month year</small>	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59										
4	___/___/___ <small>day month year</small>	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59										
3	___/___/___ <small>day month year</small>	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59										
2	___/___/___ <small>day month year</small>	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59										
1 <small>(1 week ago)</small>	___/___/___ <small>day month year</small>	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59										

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: ____ Participant Number: ____ Participant's Initials: first middle last ____

Seven-Day Physical Activity Recall (PAR) (continued)

4 Compared to your physical activity over the past three months, was last week's physical activity more, less, or about the same (check only one)?

- ₁ More
₂ Less
₃ About the same

Interviewer: Please answer questions below and note any comments on interview.

5 Were there any problems with the Seven-Day PAR interview?

- ₀ No
₁ Yes

6 Do you think this was a valid Seven-Day PAR interview?

- ₀ No
₁ Yes

7 Were there any activities reported by the participant that you don't know how to classify?

- ₀ No
₁ Yes

Center Number: ____ Participant Number: ____ Participant's Initials: first middle last

Biopsy Labs			
Sample	Date of Collection	If Not Done, Reason <i>(Use codelist below)</i>	Staff Initials
Muscle biopsy	____ / ____ / ____ <small>day month year</small>	_____	_____ <small>first middle last</small>
Fat biopsy	____ / ____ / ____ <small>day month year</small>	_____	_____ <small>first middle last</small>

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Clinic Weight

Weight date and time: _____/_____/_____ : _____
day month year 00:00 to 23:59

Staff initials: _____
first middle last

OR Not done → Specify reason (use codelist below): _____

Clinic weight (if the two measurements are more than 0.1 kg apart, measure weight a third time):

Weight 1: _____ . _____ kg

Weight 2: _____ . _____ kg

Weight 3: _____ . _____ kg

Weight of gown: _____ . _____ kg

Pregnancy Test

Complete only for females.

Does participant have reproductive potential?

₀ No

₁ Yes → If Yes: Date urine pregnancy test performed: _____/_____/_____
day month year

Results: ₁ Negative

₂ Positive

Outcomes Labs

Date and time sample collection started: _____/_____/_____ : _____
day month year 00:00 to 23:59

Sample <i>If a sample is not obtained, indicate with a Not Done.</i>	Sample Complete?	If Not Done, Reason <i>(Use codelist below)</i>	Staff Initials
Blood	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	_____	_____ <small>first middle last</small>
Vaccine Administration <i>NOTE: Before any vaccine is administered, review the vaccine questionnaire and protocol for participant eligibility.</i>		If Not Done, Reason <i>(Use codelist below)</i>	Staff Initials
Vaccine(s) given (check all that apply):	<input type="checkbox"/> Hepatitis A <input type="checkbox"/> Tetanus/diphtheria <input type="checkbox"/> Pneumococcal vaccine	_____	_____ <small>first middle last</small>

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Clinic Weight

Weight date and time: _____/_____/_____ 00:00 to 23:59
day month year

Staff initials: _____
first middle last

OR Not done → Specify reason (use Codelist below): _____

Clinic weight (if the first two measurements are more than 0.1 kg apart, measure weight a third time):

Weight 1: _____ . _____ kg

Weight 2: _____ . _____ kg

Weight 3: _____ . _____ kg

Weight of gown: _____ . _____ kg

Vital Signs

Assessment date and time: _____/_____/_____ 00:00 to 23:59
day month year

If waist measurement not done → Specify reason (use codelist below): _____

1 Natural waist measurement
(if the first two measurements are more than 1.0 cm apart, measure natural waist circumference a third time):

Staff initials: _____
first middle last

Natural waist measurement 1: _____ . _____ cm

Natural waist measurement 2: _____ . _____ cm

Natural waist measurement 3: _____ . _____ cm

2 Umbilical point waist measurement (if the first two measurements are more than 1.0 cm apart, measure umbilical point waist circumference a third time):

Umbilical point waist measurement 1: _____ . _____ cm

Umbilical point waist measurement 2: _____ . _____ cm

Umbilical point waist measurement 3: _____ . _____ cm

3 Pulse: _____ bpm OR Not done → Specify reason (use codelist below): _____

Staff initials: _____
first middle last

4 Temperature: _____ . _____ °C OR Not done → Specify reason (use codelist below): _____

Staff initials: _____
first middle last

5 Respirations: _____ per minute OR Not done → Specify reason (use codelist below): _____

Staff initials: _____
first middle last

6 Blood pressure (check only one): ₁ Left arm ₂ Right arm

Staff initials: _____
first middle last

6a Blood pressure 1: _____/_____ mm Hg Time: _____:_____ 00:00 to 23:59
systolic diastolic OR Not done → Specify reason (use codelist below): _____

6b Blood pressure 2: _____/_____ mm Hg Time: _____:_____ 00:00 to 23:59
systolic diastolic

6c Blood pressure 3: _____/_____ mm Hg Time: _____:_____ 00:00 to 23:59
systolic diastolic

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Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

12-Lead ECG		
Date and Time	Findings	Staff Initials
____ / ____ / ____ : ____ <small>day month year 00:00 to 23:59</small> OR Not done → Specify reason <small>(see codelist below):</small> _____	Is ECG (check only one): <input type="checkbox"/> ₁ Normal <input type="checkbox"/> ₂ Abnormal, not clinically significant (specify): _____ _____ <input type="checkbox"/> ₃ Abnormal, clinically significant (specify): _____ _____	_____ <small>first middle last</small>

Safety Labs			
Date and time of last meal: ____ / ____ / ____ : ____ <small>day month year 00:00 to 23:59</small>			
Date and time of sample collection: ____ / ____ / ____ : ____ <small>day month year 00:00 to 23:59</small>			
Sample	Sample Complete?	If Not Done, Reason <small>(Use codelist below)</small>	Staff Initials
Blood	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	_____	_____ <small>first middle last</small>
Urine	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	_____	_____ <small>first middle last</small>

Outcomes Labs			
Date and time of last meal: ____ / ____ / ____ : ____ <small>day month year 00:00 to 23:59</small>			
Date and time sample collection started: ____ / ____ / ____ : ____ <small>day month year 00:00 to 23:59</small>			
Sample	Sample Complete?	If Not Done, Reason <small>(Use codelist below)</small>	Staff Initials
Blood	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	_____	_____ <small>first middle last</small>
<i>If a sample is not obtained, indicate with a Not Done.</i>			

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Doubly Labeled Water (DLW)

1 Date and time of DLW dosing: _____ / _____ / _____ : _____
day month year 00:00 to 23:59 Staff initials: _____
first middle last

OR Not done → Specify reason (use codelist below): _____

2 DLW dose mixture ID and bottle number: _____ - _____ - _____ - CA

3 Exact weight of DLW mixture: _____ . _____ grams

4 Urine samples:

Collection	Sample	Date and Time Collected
Pre dosing (PD)	PDa	_____ / _____ / _____ : _____ <small>day month year 00:00 to 23:59</small>
	PDb	_____ / _____ / _____ : _____ <small>day month year 00:00 to 23:59</small>
Day 0 (Visit 1)	D0a	_____ / _____ / _____ : _____ <small>day month year 00:00 to 23:59</small>
	D0b	_____ / _____ / _____ : _____ <small>day month year 00:00 to 23:59</small>
Day 7 (Visit 2)	D7a	_____ / _____ / _____ : _____ <small>day month year 00:00 to 23:59</small>
	D7b	_____ / _____ / _____ : _____ <small>day month year 00:00 to 23:59</small>
Day 14 (Visit 4)	D14a	_____ / _____ / _____ : _____ <small>day month year 00:00 to 23:59</small>
	D14b	_____ / _____ / _____ : _____ <small>day month year 00:00 to 23:59</small>

5 Affix CRF page label(s) corresponding to this urine sample set:

Affix
Test Sample
Label Here

Affix
Retest Sample
Label Here

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: ____ Participant Number: ____ Participant's Initials:
first middle last

Pregnancy Test

Complete only for females.

Does participant have reproductive potential?

₀ No

₁ Yes → If Yes: Date urine pregnancy test performed: ____ / ____ / ____
day month year

Results: ₁ Negative

₂ Positive

DXA Scan

1 Has the participant taken a calcium supplement today?

₀ No

₁ Yes → If Yes: Proceed with scan and document in the Subject Scan Log to inform the QA Center.

2 Were any studies involving barium or radioisotopes performed within 4 weeks prior to the scheduled DXA exam?

₀ No

₁ Yes

DXA Scan		DXA Rescan OR <input type="checkbox"/> ₉₆ NA
Date of scan: ____ / ____ / ____ <small>day month year</small>		Date of rescan: ____ / ____ / ____ <small>day month year</small>
Area Scanned Check all that apply	If Not Done, Reason (Use codelist below)	Area Scanned Check all that apply
<input type="checkbox"/> Whole body	_____	<input type="checkbox"/> Whole body
<input type="checkbox"/> Forearm	_____	<input type="checkbox"/> Forearm
<input type="checkbox"/> Spine	_____	<input type="checkbox"/> Spine
<input type="checkbox"/> Hip	_____	<input type="checkbox"/> Hip

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: ____ Participant Number: ____ Participant's Initials: first middle last ____

Clinic Weight

Weight date and time: ____ / ____ / ____ : ____
day month year 00:00 to 23:59

Staff initials: first middle last ____

OR Not done → Specify reason (use Codelist below): _____

Clinic weight (if the first two measurements are more than 0.1 kg apart, measure weight a third time):

Weight 1: _____ . ____ kg

Weight 2: _____ . ____ kg

Weight 3: _____ . ____ kg

Weight of gown: _____ . ____ kg

Contraception

If Not Done → Specify reason (use codelist below): _____

Contraception method (females only):

None OR Check all that apply:

Oral contraceptive → Specify: _____

Record on Concomitant Medications page

Other → Specify (e.g., barrier, IUD): _____

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Seven-Day Physical Activity Recall (PAR)

Today's date: ____/____/____ Day (check only one): Mon Tues Wed Thurs Fri Sat Sun **OR Not done** → Specify reason (use codelist below): _____

1 Were you employed in the last seven days? No → Skip to question 3 Yes
 Interviewer initials: _____
first middle last

2 If Yes: Which days (check all that apply)?
 Mon Tues Wed Thurs Fri Sat Sun

3 Which days do you consider your weekend, or non-work, days?
 Mon Tues Wed Thurs Fri Sat Sun

Day #	Day of Week	Date	Sleep Time		Work Time		Morning (in minutes)			Afternoon (in minutes)			Evening (in minutes)		
			In Bed	Up	Start	Stop	Mod.	Hard	Very Hard	Mod.	Hard	Very Hard	Mod.	Hard	Very Hard
7	(yesterday)	____/____/____ <small>day month year</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>
6		____/____/____ <small>day month year</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>
5		____/____/____ <small>day month year</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>
4		____/____/____ <small>day month year</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>
3		____/____/____ <small>day month year</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>
2		____/____/____ <small>day month year</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>
1	(1 week ago)	____/____/____ <small>day month year</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: ____ Participant Number: ____ Participant's Initials: first middle last ____

Seven-Day Physical Activity Recall (PAR) (continued)

4 Compared to your physical activity over the past three months, was last week's physical activity more, less, or about the same (check only one)?

- ₁ More
₂ Less
₃ About the same

Interviewer: Please answer questions below and note any comments on interview.

5 Were there any problems with the Seven-Day PAR interview?

- ₀ No
₁ Yes

6 Do you think this was a valid Seven-Day PAR interview?

- ₀ No
₁ Yes

7 Were there any activities reported by the participant that you don't know how to classify?

- ₀ No
₁ Yes

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

6-Day Food Record

Complete below OR Not done → Specify reason (use Codelist below): _____ Staff initials: _____
first middle last

			Replacement Values		
Day of DLW	Date of Record	Record Quality (check only one)	Day of DLW	Date of Record	Record Quality (check only one)
1	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing	8	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing
2	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing	9	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing
3	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing	10	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing
4	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing	11	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing
5	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing	12	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing
6	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing	13	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: ____ Participant Number: ____ Participant's Initials: first middle last ____

Date completed: ____/____/____ OR Not done → Specify reason (use codelist below): ____
day month year

BDI-II

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully and then pick out the one statement in each group that best describes the way you have been feeling during the past two weeks, including today. Check the box beside the statement you have picked. Be sure that you check only one statement for each group, including item 16 and item 18.

- 1 Sadness:**

 - ₀ I do not feel sad
 - ₁ I feel sad much of the time
 - ₂ I am sad all of the time
 - ₃ I am so sad or unhappy that I can't stand it

- 2 Pessimism:**

 - ₀ I am not discouraged about my future
 - ₁ I feel more discouraged about my future than I used to be
 - ₂ I do not expect things to work out for me
 - ₃ I feel my future is hopeless and will only get worse

- 3 Past failure:**

 - ₀ I do not feel like a failure
 - ₁ I have failed more than I should have
 - ₂ As I look back, I see a lot of failures
 - ₃ I feel I am a total failure as a person

- 4 Loss of pleasure:**

 - ₀ I get as much pleasure as I ever did from the things I enjoy
 - ₁ I don't enjoy things as much as I used to
 - ₂ I get very little pleasure from the things I used to enjoy
 - ₃ I can't get any pleasure from the things I used to enjoy

- 5 Guilty feelings:**

 - ₀ I don't feel particularly guilty
 - ₁ I feel guilty over many things I have done or should have done
 - ₂ I feel quite guilty most of the time
 - ₃ I feel guilty all of the time

- 6 Punishment feelings:**

 - ₀ I don't feel I am being punished
 - ₁ I feel I may be punished
 - ₂ I expect to be punished
 - ₃ I feel I am being punished

- 7 Self-dislike:**

 - ₀ I feel the same about myself as ever
 - ₁ I have lost confidence in myself
 - ₂ I am disappointed in myself
 - ₃ I dislike myself

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Participant's Initials: first middle last ____

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Center Number: ____ Participant Number: ____ Participant's Initials:
first middle last

BDI-II (continued)

- 8 Self-criticalness:**
- ₀ I don't criticize or blame myself more than usual
 - ₁ I am more critical of myself than I used to be
 - ₂ I criticize myself for all of my faults
 - ₃ I blame myself for everything bad that happens
- 9 Suicidal thoughts or wishes:**
- ₀ I don't have any thoughts of killing myself
 - ₁ I have thoughts of killing myself but I would not carry them out
 - ₂ I would like to kill myself
 - ₃ I would kill myself if I had the chance
- 10 Crying:**
- ₀ I don't cry any more than I used to
 - ₁ I cry more than I used to
 - ₂ I cry over every little thing
 - ₃ I feel like crying, but I can't
- 11 Agitation:**
- ₀ I am no more wound up or restless than usual
 - ₁ I feel more restless or wound up than usual
 - ₂ I am so restless or agitated that it's hard to stay still
 - ₃ I am so restless or agitated that I have to keep moving or doing something
- 12 Loss of interest:**
- ₀ I have not lost interest in other people or activities
 - ₁ I am less interested in other people or things than before
 - ₂ I have lost most of my interest in other people or things
 - ₃ It's hard to get interested in anything
- 13 Indecisiveness:**
- ₀ I make decisions about as well as ever
 - ₁ I find it more difficult to make decisions than usual
 - ₂ I have much greater difficulty in making decisions than I used to
 - ₃ I have trouble making my decisions
- 14 Worthlessness:**
- ₀ I do not feel I am worthless
 - ₁ I don't consider myself as worthwhile and useful as I used to
 - ₂ I feel more worthless as compared to other people
 - ₃ I feel utterly worthless
- 15 Loss of energy:**
- ₀ I have as much energy as ever
 - ₁ I have less energy than I used to have
 - ₂ I don't have enough energy to do very much
 - ₃ I don't have enough energy to do anything

Participant's Initials:
first middle last

Center Number: ____ Participant Number: ____ Participant's Initials: first middle last ____

BDI-II (continued)

- 16 Changes in sleeping pattern:**
- ₀ I have not experienced any change in my sleeping pattern
 - ₁ I sleep somewhat more than usual
 - ₂ I sleep somewhat less than usual
 - ₃ I sleep a lot more than usual
 - ₄ I sleep a lot less than usual
 - ₅ I sleep most of the day
 - ₆ I wake up 1-2 hours early and can't get back to sleep
- 17 Irritability:**
- ₀ I am no more irritable than usual
 - ₁ I am more irritable than usual
 - ₂ I am much more irritable than usual
 - ₃ I am irritable all of the time
- 18 Changes in appetite:**
- ₀ I have not experienced any change in my appetite
 - ₁ My appetite is somewhat less than usual
 - ₂ My appetite is somewhat greater than usual
 - ₃ My appetite is much less than before
 - ₄ My appetite is much greater than usual
 - ₅ I have no appetite at all
 - ₆ I crave food all of the time
- 19 Concentration difficulty:**
- ₀ I can concentrate as well as ever
 - ₁ I can't concentrate as well as usual
 - ₂ It's hard to keep my mind on anything for very long
 - ₃ I find I can't concentrate on anything
- 20 Tiredness or fatigue:**
- ₀ I am no more tired or fatigued than usual
 - ₁ I get more tired or fatigued more easily than usual
 - ₂ I am too tired or fatigued to do a lot of the things I used to do
 - ₃ I am too tired or fatigued to do most of the things I used to do
- 21 Loss of interest in sex:**
- ₀ I have not noticed any recent change in my interest in sex
 - ₁ I am less interested in sex than I used to be
 - ₂ I am much less interested in sex now
 - ₃ I have lost interest in sex completely

Participant's Initials: first middle last ____

Center Number: ____ Participant Number: _____ Participant's Initials: _____
first middle last

Date completed: ____/____/____ OR Not done → Specify reason (use codelist below): ____
day month year

Multiaxial Assessment of Eating Disorder Symptoms (MAEDS)

Instructions: Using the scale shown, please rate the following items on a scale from 1 to 7. Please answer as truthfully as possible.

	Never	Very Rarely	Rarely	Sometimes	Often	Very Often	Always
1 Fasting is a good way to lose weight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
2 My sleep isn't as good as it used to be.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
3 I avoid eating for as long as I can.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
4 Certain foods are "forbidden" for me to eat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
5 I can't keep certain foods in my house because I will binge on them.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
6 I can easily make myself vomit.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
7 I can feel that being fat is terrible.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
8 I avoid greasy foods.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
9 It's okay to binge and purge once in a while.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
10 I don't eat certain foods.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
11 I think I am a good person.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
12 My eating is normal.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
13 I can't seem to concentrate lately.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
14 I try to diet by fasting.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
15 I vomit to control my weight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
16 Lately nothing seems enjoyable anymore.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
17 Laxatives help keep you slim.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
18 I don't eat red meat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
19 I eat so rapidly I can't even taste my food.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Participant's Initials: _____
first middle last

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Center Number: ____ Participant Number: ____ Participant's Initials: first middle last _____

Multiaxial Assessment of Eating Disorder Symptoms (MAEDS) (continued)

	Never	Very Rarely	Rarely	Some-times	Often	Very Often	Always
20 I do everything I can to avoid being overweight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
21 When I feel bloated, I must do something to rid myself of that feeling.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
22 I overeat too frequently.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
23 It's okay to be overweight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
24 Recently I have felt that I am a worthless person.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
25 I would be very upset if I gained 2 pounds.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
26 I crave sweets and carbohydrates.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
27 I lose control when I eat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
28 Being fat would be terrible.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
29 I have thought seriously about suicide lately.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
30 I don't have any energy anymore.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
31 I eat small portions to control my weight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
32 I eat 3 meals a day.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
33 Lately I have been easily irritated.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
34 Some foods should be totally avoided.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
35 I use laxatives to control my weight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
36 I am terrified by the thought of being overweight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
37 Purging is a good way to lose weight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
38 I avoid fatty foods.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇

Participant's Initials: first middle last _____

Center Number: ____ Participant Number: ____ Participant's Initials: _____
first middle last

Multiaxial Assessment of Eating Disorder Symptoms (MAEDS) (continued)

	Never	Very Rarely	Rarely	Sometimes	Often	Very Often	Always
39 Recently I have felt pretty blue.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
40 I am obsessed with becoming overweight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
41 I don't eat fried foods.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
42 I skip meals.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
43 Fat people are unhappy.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
44 People are too concerned with the way I eat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
45 I feel good when I skip meals.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
46 I avoid foods with sugar.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
47 I hate it when I feel fat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
48 I am too fat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
49 I eat until I am completely stuffed.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
50 I hate to eat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
51 I feel guilty about a lot of things these days.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
52 I'm very careful of what I eat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
53 I can "hold off" and not eat even if I am hungry.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
54 I eat even when I am not hungry.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
55 Fat people are disgusting.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
56 I wouldn't mind gaining a few pounds.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇

Participant's Initials: _____
first middle last

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Inpatient Admission and Discharge

1 Inpatient admission date and time: _____/_____/_____ _____:_____
day month year 00:00 to 23:59

2 Inpatient discharge date and time: _____/_____/_____ _____:_____
day month year 00:00 to 23:59

Clinic Weight

Weight date and time: _____/_____/_____ _____:_____
day month year 00:00 to 23:59

Staff initials: _____
first middle last

OR Not done → Specify reason (use codelist below): _____

Clinic weight (if the two measurements are more than 0.1 kg apart, measure weight a third time):

Weight 1: _____ . ____ kg

Weight 2: _____ . ____ kg

Weight 3: _____ . ____ kg

Weight of gown: _____ . ____ kg

Metabolic Rate

Sample	Date of Collection	If Not Done, Reason (Use codelist below)	Staff Initials
Resting Metabolic Rate (RMR)—Visit 5	_____/_____/_____ <small>day month year</small>	_____	_____ <small>first middle last</small>
Cart ID	<input type="checkbox"/> Tufts-003 (623-002) <input type="checkbox"/> WASH U-001 (623-003) <input type="checkbox"/> PBRC-016 (623-005) <input type="checkbox"/> Tufts-006 (623-006) <input type="checkbox"/> WASH U-002 (623-004) <input type="checkbox"/> PBRC-017 (623-001)		

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Seven-Day Physical Activity Recall (PAR)

Today's date: ____/____/____ Day (check only one): Mon Tues Wed Thurs Fri Sat Sun OR Not done → Specify reason (use code list below): _____

Interviewer initials: _____
first middle last

- Were you employed in the last seven days? No → Skip to question 3 Yes
- If Yes: Which days (check all that apply)?
 Mon Tues Wed Thurs Fri Sat Sun
- Which days do you consider your weekend, or non-work, days?
 Mon Tues Wed Thurs Fri Sat Sun

Day #	Date	Sleep Time		Work Time			Morning (in minutes)			Afternoon (in minutes)			Evening (in minutes)		
		In Bed	Up	Start	Stop	Mod.	Hard	Very Hard	Mod.	Hard	Very Hard	Mod.	Hard	Very Hard	
7 <small>(yester-day)</small>	____/____/____ <small>day month year</small>	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	
6	____/____/____ <small>day month year</small>	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	
5	____/____/____ <small>day month year</small>	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	
4	____/____/____ <small>day month year</small>	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	
3	____/____/____ <small>day month year</small>	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	
2	____/____/____ <small>day month year</small>	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	
1 <small>(1 week ago)</small>	____/____/____ <small>day month year</small>	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	00:00 to 23:59 00:00 to 23:59	

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: ____ Participant Number: ____ Participant's Initials: first middle last ____

Seven-Day Physical Activity Recall (PAR) (continued)

4 Compared to your physical activity over the past three months, was last week's physical activity more, less, or about the same (check only one)?

- ₁ More
₂ Less
₃ About the same

Interviewer: Please answer questions below and note any comments on interview.

5 Were there any problems with the Seven-Day PAR interview?

- ₀ No
₁ Yes

6 Do you think this was a valid Seven-Day PAR interview?

- ₀ No
₁ Yes

7 Were there any activities reported by the participant that you don't know how to classify?

- ₀ No
₁ Yes

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Clinic Weight

Weight date and time: ____/____/____ : ____
day month year 00:00 to 23:59

Staff initials: _____
first middle last

OR Not done → Specify reason (use codelist below): ____

Clinic weight (if the two measurements are more than 0.1 kg apart, measure weight a third time):

Weight 1: _____ . ____ kg

Weight 2: _____ . ____ kg

Weight 3: _____ . ____ kg

Weight of gown: _____ . ____ kg

Pregnancy Test

Complete only for females.

Does participant have reproductive potential?

₀ No

₁ Yes → If Yes: Date urine pregnancy test performed: ____/____/____
day month year

Results: ₁ Negative

₂ Positive

Outcomes Labs

Date and time sample collection started: ____/____/____ : ____
day month year 00:00 to 23:59

Sample	Sample Complete?	If Not Done, Reason (Use codelist below)	Staff Initials
<i>If a sample is not obtained, indicate with a Not Done.</i>			
Blood	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	_____	_____ <small>first middle last</small>
Vaccine Administration <i>NOTE: Before any vaccine is administered, review the vaccine questionnaire and protocol for participant eligibility.</i>			
Vaccine(s) given:	<input type="checkbox"/> Hepatitis A	_____	_____ <small>first middle last</small>

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Clinic Weight

Weight date and time: _____/_____/_____ 00:00 to 23:59
day month year

Staff initials: _____
first middle last

OR Not done → Specify reason (use Codelist below): _____

Clinic weight (if the first two measurements are more than 0.1 kg apart, measure weight a third time):

Weight 1: _____ . _____ kg

Weight 2: _____ . _____ kg

Weight 3: _____ . _____ kg

Weight of gown: _____ . _____ kg

Vital Signs

Assessment date and time: _____/_____/_____ 00:00 to 23:59
day month year

If waist measurement not done → Specify reason (use codelist below): _____

1 Natural waist measurement
 (if the first two measurements are more than 1.0 cm apart, measure natural waist circumference a third time):

Staff initials: _____
first middle last

Natural waist measurement 1: _____ . _____ cm

Natural waist measurement 2: _____ . _____ cm

Natural waist measurement 3: _____ . _____ cm

2 Umbilical point waist measurement (if the first two measurements are more than 1.0 cm apart, measure umbilical point waist circumference a third time):

Umbilical point waist measurement 1: _____ . _____ cm

Umbilical point waist measurement 2: _____ . _____ cm

Umbilical point waist measurement 3: _____ . _____ cm

3 Pulse: _____ bpm OR Not done → Specify reason (use codelist below): _____

Staff initials: _____
first middle last

4 Temperature: _____ . _____ °C OR Not done → Specify reason (use codelist below): _____

Staff initials: _____
first middle last

5 Respirations: _____ per minute OR Not done → Specify reason (use codelist below): _____

Staff initials: _____
first middle last

6 Blood pressure (check only one): ₁ Left arm ₂ Right arm

Staff initials: _____
first middle last

6a Blood pressure 1: _____/_____ mm Hg Time: _____:_____
systolic diastolic 00:00 to 23:59 OR Not done → Specify reason (use codelist below): _____

6b Blood pressure 2: _____/_____ mm Hg Time: _____:_____
systolic diastolic 00:00 to 23:59

6c Blood pressure 3: _____/_____ mm Hg Time: _____:_____
systolic diastolic 00:00 to 23:59

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

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Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

12-Lead ECG

Date and Time	Findings	Staff Initials
____ / ____ / ____ : ____ <small>day month year 00:00 to 23:59</small> OR Not done → Specify reason <small>(see codelist below):</small> _____	Is ECG (check only one): <input type="checkbox"/> ₁ Normal <input type="checkbox"/> ₂ Abnormal, not clinically significant (specify): _____ _____ <input type="checkbox"/> ₃ Abnormal, clinically significant (specify): _____ _____	 <small>first middle last</small>

Safety Labs

Date and time of last meal: ____ / ____ / ____ : ____
day month year 00:00 to 23:59

Date and time of sample collection: ____ / ____ / ____ : ____
day month year 00:00 to 23:59

Sample	Sample Complete?	If Not Done, Reason <small>(Use codelist below)</small>	Staff Initials
Blood	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	_____	<small>first middle last</small>
Urine	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	_____	<small>first middle last</small>

Pregnancy Test

Complete only for females.

Does participant have reproductive potential?

₀ No

₁ Yes → If Yes: Date urine pregnancy test performed: ____ / ____ / ____
day month year

Results: ₁ Negative

₂ Positive

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Doubly Labeled Water (DLW)

1 Date and time of DLW dosing: _____ / _____ / _____ : _____
day month year 00:00 to 23:59 Staff initials: _____
first middle last

OR Not done → Specify reason (use codelist below): _____

2 DLW dose mixture ID and bottle number: _____ - _____ - _____ - CA

3 Exact weight of DLW mixture: _____ . _____ grams

4 Urine samples:

Collection	Sample	Date and Time Collected
Pre dosing (PD)	PDa	_____ / _____ / _____ : _____ <small>day month year 00:00 to 23:59</small>
	PDb	_____ / _____ / _____ : _____ <small>day month year 00:00 to 23:59</small>
Day 0 (Visit 1)	D0a	_____ / _____ / _____ : _____ <small>day month year 00:00 to 23:59</small>
	D0b	_____ / _____ / _____ : _____ <small>day month year 00:00 to 23:59</small>
Day 7 (Visit 2)	D7a	_____ / _____ / _____ : _____ <small>day month year 00:00 to 23:59</small>
	D7b	_____ / _____ / _____ : _____ <small>day month year 00:00 to 23:59</small>
Day 14 (Visit 4)	D14a	_____ / _____ / _____ : _____ <small>day month year 00:00 to 23:59</small>
	D14b	_____ / _____ / _____ : _____ <small>day month year 00:00 to 23:59</small>

5 Affix CRF page label(s) corresponding to this urine sample set:

**Affix
Test Sample
Label Here**

**Affix
Retest Sample
Label Here**

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Physical Examination

Date of examination: ____/____/____
day month year

Staff initials: _____
first middle last

OR Not done → Specify reason (use codelist below): _____

Body System	Assessments			If Abnormal or Not Done: Explain
	Normal	Abnormal	Not Done	
1 General appearance:	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀ →	<input type="checkbox"/> ₉₇ →	
2 Head, Ears, Eyes, Nose, Throat:	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀ →	<input type="checkbox"/> ₉₇ →	
3 Neck:	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀ →	<input type="checkbox"/> ₉₇ →	
4 Heart:	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀ →	<input type="checkbox"/> ₉₇ →	
5 Lungs:	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀ →	<input type="checkbox"/> ₉₇ →	
6 Abdomen:	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀ →	<input type="checkbox"/> ₉₇ →	
7 Lymph nodes:	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀ →	<input type="checkbox"/> ₉₇ →	
8 Extremities/Skin:	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀ →	<input type="checkbox"/> ₉₇ →	
9 Neurological:	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀ →	<input type="checkbox"/> ₉₇ →	
10 Musculoskeletal:	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀ →	<input type="checkbox"/> ₉₇ →	
	Normal	Abnormal	Not Done*	
11 Genitourinary:	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀ →	<input type="checkbox"/> ₉₇ →	
12 Breast:	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀ →	<input type="checkbox"/> ₉₇ →	

Physician's Signature

Investigator: _____
signature

Date: ____/____/____
day month year

* Not done at this examination OR Referred participant to primary care physician for exam.

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

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Center Number: ____ Participant Number: ____ Participant's Initials: first middle last ____

DXA Scan

1 Has the participant taken a calcium supplement today?

₀ No ₁ Yes → If Yes: Proceed with scan and document in the Subject Scan Log to inform the QA Center.

2 Were any studies involving barium or radioisotopes performed within 4 weeks prior to the scheduled DXA exam?

₀ No ₁ Yes

DXA Scan		DXA Rescan OR <input type="checkbox"/> ₉₆ NA
Date of scan: ____/____/____ <small>day month year</small>		Date of rescan: ____/____/____ <small>day month year</small>
Area Scanned Check all that apply	If Not Done, Reason (Use codelist below)	Area Scanned Check all that apply
<input type="checkbox"/> Whole body	_____	<input type="checkbox"/> Whole body
<input type="checkbox"/> Forearm	_____	<input type="checkbox"/> Forearm
<input type="checkbox"/> Spine	_____	<input type="checkbox"/> Spine
<input type="checkbox"/> Hip	_____	<input type="checkbox"/> Hip

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Date completed: ____/____/____ OR Not done → Specify reason (use codelist below): _____
day month year

RAND SF-36

Instructions: This survey asks for your views about your health. This information will help keep track of how well you are able to do your usual activities. Please answer every question by placing a check "X" in the appropriate box. If you are unsure about how to answer a question, give the best answer you can.

1 In general, would you say your health is: ₁ Excellent ₂ Very good ₃ Good ₄ Fair ₅ Poor

2 Compared to one year ago, how would you rate your health in general now?
₁ Much better now than 1 year ago
₂ Somewhat better now than 1 year ago
₃ About the same
₄ Somewhat worse now than 1 year ago
₅ Much worse now than 1 year ago

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes, Limited A Lot	Yes, Limited A Little	No, Not Limited At All
--	--------------------	-----------------------	------------------------

3 Vigorous activities , such as running, lifting heavy objects, participating in strenuous sports	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
---	---------------------------------------	---------------------------------------	---------------------------------------

4 Moderate activities , such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
--	---------------------------------------	---------------------------------------	---------------------------------------

5 Lifting or carrying groceries	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
--	---------------------------------------	---------------------------------------	---------------------------------------

6 Climbing several flights of stairs	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
--	---------------------------------------	---------------------------------------	---------------------------------------

7 Climbing one flight of stairs	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
---	---------------------------------------	---------------------------------------	---------------------------------------

8 Bending, kneeling or stooping	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
--	---------------------------------------	---------------------------------------	---------------------------------------

9 Walking more than a mile	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
--	---------------------------------------	---------------------------------------	---------------------------------------

10 Walking several blocks	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
---	---------------------------------------	---------------------------------------	---------------------------------------

11 Walking one block	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
------------------------------------	---------------------------------------	---------------------------------------	---------------------------------------

12 Bathing or dressing yourself	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
--	---------------------------------------	---------------------------------------	---------------------------------------

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Participant's Initials: _____
first middle last

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Center Number: ____ Participant Number: ____ Participant's Initials: _____
first middle last

Rand SF-36 (continued)

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

Yes **No**

13 Cut down on the **amount of time** you spent on work or other activities ₁ ₂

14 **Accomplished less** than you would like ₁ ₂

15 Were limited in the **kind** of work or other activities ₁ ₂

16 Had **difficulty** performing the work or other activities
(for example, it took extra effort) ₁ ₂

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)

Yes **No**

17 Cut down on the **amount of time** you spent on work or other activities ₁ ₂

18 **Accomplished less** than you would like ₁ ₂

19 Didn't do work or other activities as **carefully** as usual ₁ ₂

20 During the **past 4 weeks**, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors or groups?

- ₁ Not at all
- ₂ Slightly
- ₃ Moderately
- ₄ Quite a bit
- ₅ Extremely

21 How much **bodily** pain have you had during the **past 4 weeks**?

- ₁ None
- ₂ Very mild
- ₃ Mild
- ₄ Moderate
- ₅ Severe
- ₆ Very severe

22 During the **past 4 weeks**, how much did pain interfere with your normal work (including both work outside the home and housework)?

- ₁ Not at all
- ₂ A little bit
- ₃ Moderately
- ₄ Quite a bit
- ₅ Extremely

Participant's Initials: _____
first middle last

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Center Number: ____ Participant Number: ____ Participant's Initials: first middle last ____

RAND SF-36 (continued)

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks...	All of the Time	Most of the Time	A Good Bit of the Time	Some of the Time	A Little of the Time	None of the Time
23 Did you feel full of pep?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
24 Have you been a very nervous person?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
25 Have you felt so down in the dumps that nothing could cheer you up?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
26 Have you felt calm and peaceful?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
27 Did you have a lot of energy?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
28 Have you felt downhearted and blue?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
29 Did you feel worn out?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
30 Have you been a happy person?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
31 Did you feel tired?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
32 During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc)?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	
	All of the Time	Most of the Time	Some of the Time	A Little of the Time	None of the Time	
How true or false is each of the following statements for you?	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False	
33 I seem to get sick a little easier than other people.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	
34 I am healthy as anybody I know.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	
35 I expect my health to get worse.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	
36 My health is excellent.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	

Participant's Initials: first middle last ____

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Date completed: ____/____/____ OR Not done → Specify reason (use codelist below): ____
day month year

BDI-II

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully and then pick out the one statement in each group that best describes the way you have been feeling during the past two weeks, including today. Check the box beside the statement you have picked. Be sure that you check only one statement for each group, including item 16 and item 18.

- 1 Sadness:**
- ₀ I do not feel sad
 - ₁ I feel sad much of the time
 - ₂ I am sad all of the time
 - ₃ I am so sad or unhappy that I can't stand it
- 2 Pessimism:**
- ₀ I am not discouraged about my future
 - ₁ I feel more discouraged about my future than I used to be
 - ₂ I do not expect things to work out for me
 - ₃ I feel my future is hopeless and will only get worse
- 3 Past failure:**
- ₀ I do not feel like a failure
 - ₁ I have failed more than I should have
 - ₂ As I look back, I see a lot of failures
 - ₃ I feel I am a total failure as a person
- 4 Loss of pleasure:**
- ₀ I get as much pleasure as I ever did from the things I enjoy
 - ₁ I don't enjoy things as much as I used to
 - ₂ I get very little pleasure from the things I used to enjoy
 - ₃ I can't get any pleasure from the things I used to enjoy
- 5 Guilty feelings:**
- ₀ I don't feel particularly guilty
 - ₁ I feel guilty over many things I have done or should have done
 - ₂ I feel quite guilty most of the time
 - ₃ I feel guilty all of the time
- 6 Punishment feelings:**
- ₀ I don't feel I am being punished
 - ₁ I feel I may be punished
 - ₂ I expect to be punished
 - ₃ I feel I am being punished
- 7 Self-dislike:**
- ₀ I feel the same about myself as ever
 - ₁ I have lost confidence in myself
 - ₂ I am disappointed in myself
 - ₃ I dislike myself

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Participant's Initials: first middle last ____

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Center Number: ____ Participant Number: ____ Participant's Initials: first middle last ____

BDI-II (continued)

- 8 Self-criticalness:**
- ₀ I don't criticize or blame myself more than usual
 - ₁ I am more critical of myself than I used to be
 - ₂ I criticize myself for all of my faults
 - ₃ I blame myself for everything bad that happens
- 9 Suicidal thoughts or wishes:**
- ₀ I don't have any thoughts of killing myself
 - ₁ I have thoughts of killing myself but I would not carry them out
 - ₂ I would like to kill myself
 - ₃ I would kill myself if I had the chance
- 10 Crying:**
- ₀ I don't cry any more than I used to
 - ₁ I cry more than I used to
 - ₂ I cry over every little thing
 - ₃ I feel like crying, but I can't
- 11 Agitation:**
- ₀ I am no more wound up or restless than usual
 - ₁ I feel more restless or wound up than usual
 - ₂ I am so restless or agitated that it's hard to stay still
 - ₃ I am so restless or agitated that I have to keep moving or doing something
- 12 Loss of interest:**
- ₀ I have not lost interest in other people or activities
 - ₁ I am less interested in other people or things than before
 - ₂ I have lost most of my interest in other people or things
 - ₃ It's hard to get interested in anything
- 13 Indecisiveness:**
- ₀ I make decisions about as well as ever
 - ₁ I find it more difficult to make decisions than usual
 - ₂ I have much greater difficulty in making decisions than I used to
 - ₃ I have trouble making my decisions
- 14 Worthlessness:**
- ₀ I do not feel I am worthless
 - ₁ I don't consider myself as worthwhile and useful as I used to
 - ₂ I feel more worthless as compared to other people
 - ₃ I feel utterly worthless
- 15 Loss of energy:**
- ₀ I have as much energy as ever
 - ₁ I have less energy than I used to have
 - ₂ I don't have enough energy to do very much
 - ₃ I don't have enough energy to do anything

Participant's Initials: first middle last ____

Center Number: ____ Participant Number: ____ Participant's Initials: first middle last ____

BDI-II (continued)

- 16 Changes in sleeping pattern:**
- ₀ I have not experienced any change in my sleeping pattern
 - ₁ I sleep somewhat more than usual
 - ₂ I sleep somewhat less than usual
 - ₃ I sleep a lot more than usual
 - ₄ I sleep a lot less than usual
 - ₅ I sleep most of the day
 - ₆ I wake up 1-2 hours early and can't get back to sleep
- 17 Irritability:**
- ₀ I am no more irritable than usual
 - ₁ I am more irritable than usual
 - ₂ I am much more irritable than usual
 - ₃ I am irritable all of the time
- 18 Changes in appetite:**
- ₀ I have not experienced any change in my appetite
 - ₁ My appetite is somewhat less than usual
 - ₂ My appetite is somewhat greater than usual
 - ₃ My appetite is much less than before
 - ₄ My appetite is much greater than usual
 - ₅ I have no appetite at all
 - ₆ I crave food all of the time
- 19 Concentration difficulty:**
- ₀ I can concentrate as well as ever
 - ₁ I can't concentrate as well as usual
 - ₂ It's hard to keep my mind on anything for very long
 - ₃ I find I can't concentrate on anything
- 20 Tiredness or fatigue:**
- ₀ I am no more tired or fatigued than usual
 - ₁ I get more tired or fatigued more easily than usual
 - ₂ I am too tired or fatigued to do a lot of the things I used to do
 - ₃ I am too tired or fatigued to do most of the things I used to do
- 21 Loss of interest in sex:**
- ₀ I have not noticed any recent change in my interest in sex
 - ₁ I am less interested in sex than I used to be
 - ₂ I am much less interested in sex now
 - ₃ I have lost interest in sex completely

Participant's Initials: first middle last ____

Center Number: ____ Participant Number: ____ Participant's Initials: first middle last ____

Date completed: ____/____/____ OR Not done → Specify reason (use codelist below): _____
day month year

Profile of Mood States

Instructions: Please describe **how you feel right now** by checking one box for each of the words listed below.

Feeling	Not At All	A Little	Moderately	Quite A Bit	Extremely
1 Friendly	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
2 Tense	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
3 Angry	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
4 Worn out	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
5 Unhappy	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
6 Clear-headed	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
7 Lively	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
8 Confused	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
9 Sorry for things done	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
10 Shaky	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
11 Listless	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
12 Peeved	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
13 Considerate	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
14 Sad	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
15 Active	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
16 On edge	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
17 Grouchy	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
18 Blue	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
19 Energetic	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
20 Panicky	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

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Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Participant's Initials: first middle last ____

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Center Number: ____ Participant Number: ____ Participant's Initials: first middle last ____

Profile of Mood States (continued)

Feeling	Not At All	A Little	Moderately	Quite A Bit	Extremely
21 Hopeless	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
22 Relaxed	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
23 Unworthy	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
24 Spiteful	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
25 Sympathetic	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
26 Uneasy	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
27 Restless	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
28 Unable to concentrate	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
29 Fatigued	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
30 Helpful	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
31 Annoyed	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
32 Discouraged	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
33 Resentful	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
34 Nervous	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
35 Lonely	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
36 Miserable	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
37 Muddled	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
38 Cheerful	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
39 Bitter	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
40 Exhausted	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
41 Anxious	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
42 Ready to fight	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
43 Good-natured	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

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Profile of Mood States (continued)

Feeling	Not At All	A Little	Moderately	Quite A Bit	Extremely
44 Gloomy	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
45 Desperate	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
46 Sluggish	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
47 Rebellious	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
48 Helpless	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
49 Weary	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
50 Bewildered	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
51 Alert	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
52 Deceived	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
53 Furious	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
54 Efficient	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
55 Trusting	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
56 Full of pep	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
57 Bad-tempered	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
58 Worthless	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
59 Forgetful	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
60 Carefree	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
61 Terrified	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
62 Guilty	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
63 Vigorous	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
64 Uncertain about things	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
65 Bushed	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

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day month year

Perceived Stress Scale (PSS)

Instructions: The questions in this scale ask you about your feelings and thoughts during the last month. In each case, please indicate how often you felt or thought a certain way. Please check only one answer for each question.

	Never	Almost Never	Some- times	Fairly Often	Very Often
1 In the last month, how often have you felt that you were unable to control the important things in your life?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
2 In the last month, how often have you felt confident about your ability to handle your personal problems?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
3 In the last month, how often have you felt that things were going your way?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
4 In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

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day month year

Pittsburgh Sleep Quality Index (PSQI)

Instructions: The following questions relate to your usual sleep habits during the past month only. Your answers should indicate the most accurate reply for the majority of days and nights in the past month. Please answer all questions.

During the past month...

1 When have you usually gone to bed? _____ : _____
00:00 to 23:59

2 How long (in minutes) has it taken you to fall asleep each night? _____ minutes

3 When have you usually gotten up in the morning? _____ : _____
00:00 to 23:59

4 How many hours of actual sleep did you get at night?
(This may be different than the number of hours you spend in bed.) ____ . ____ hours

5 During the past month, how often have you had trouble sleeping because you... (check only one answer per question)	Not during the past month	Less than once a week	Once or twice a week	3 or more times a week
a Cannot get to sleep within 30 minutes	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
b Wake up in the middle of the night or early morning	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
c Have to get up to use the bathroom	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
d Cannot breathe comfortably	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
e Cough or snore loudly	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
f Feel too cold	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
g Feel too hot	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
h Have bad dreams	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
i Have pain	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
j Other reason(s), please describe, including how often you have had trouble sleeping because of this reason(s): _____	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
6 During the past month, how often have you taken medicine (prescribed or "over the counter") to help you sleep?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃

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Pittsburgh Sleep Quality Index (PSQI) (continued)

	Never	Once or twice	Once or twice each week	3 or more times each week
7 During the past month, how often have you had trouble staying awake while driving, eating meals, or engaging in social activity?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
	No problem at all	Only a very slight problem	Somewhat of a problem	A very big problem
8 During the past month, how much of a problem has it been for you to keep up enthusiasm to get things done?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
	Very good	Fairly good	Fairly bad	Very bad
9 During the past month, how would you rate your sleep quality overall?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃

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Derogatis Interview for Sexual Function (DISF-SR) (F) Female Version

Instruction: Below you will find a brief set of questions about your sexual activities. The questions are divided into different sections that ask about different aspects of your sexual experiences. One section asks about **sexual fantasies** or daydreams, while another inquires about the kinds of **sexual experiences** that you have. You are also asked about the nature of your **sexual arousal** and the quality of your **orgasm**. There are also a few other questions about different areas of your sexual relationship.

On some questions you are asked to respond in terms of a frequency scale, that is, "how often" do you perform the sexual activities asked about in that section. Some frequency scales go from "0 = not at all" to "8 = four or more times a day." Other frequency scales range from "0 = never" to "4 = always." In the case of other questions, you will be asked to respond in terms of a satisfaction scale. This type of scale tells how much you enjoyed, or were satisfied by the sexual activity being asked about. Some satisfaction scales range from "0 = could not be worse" to "8 = could not be better." Other satisfaction scales go from "0 = not at all satisfied," to "4 = extremely satisfied."

In every section of the inventory the scales required for that section are printed just above the questions so it will be easy to follow. Although it is brief, take your time with the inventory. **For each item, please check the scale number that best describes your personal experience.**

If you have any questions, please ask the person who gave you the inventory for help.

Section 1—Sexual Cognition/Fantasy

During the past 30 days or since the last time you filled out this inventory, how often have you had thoughts, dreams, or fantasies about:	Not at all	Less than 1 per month	1 or 2 per month	1 per week	2 or 3 per week	4 to 6 per week	1 per day	2 or 3 per day	4 or more per day
1.1 A sexually attractive person	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
1.2 Erotic parts of a man's body (e.g., face, shoulders, legs)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
1.3 Erotic or romantic situations	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
1.4 Caressing, touching, undressing, or foreplay	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
1.5 Sexual intercourse, oral sex, touching to orgasm	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈

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Derogatis Interview for Sexual Function (DISF-SR) (F) Female Version (continued)

Section 2—Sexual Arousal

During the past 30 days or since the last time you filled out this inventory, how often did you have the following experiences?	Not at all	Less than 1 per month	1 or 2 per month	1 per week	2 or 3 per week	4 to 6 per week	1 per day	2 or 3 per day	4 or more per day
2.1 Feel sexually aroused while alone	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
2.2 Actively seek sexual satisfaction	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
2.3 Feel sexually aroused with a partner	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
	Never	Rarely	Sometimes	Usually	Always				
2.4 Have normal lubrication with masturbation	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄				
2.5 Have normal lubrication throughout sexual relations	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄				

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Derogatis Interview for Sexual Function (DISF-SR) (F) Female Version (continued)

Section 3—Sexual Behavior/Experiences

During the past 30 days or since the last time you filled out the inventory, how often did you engage in the following sexual activities?	Not at all	Less than 1 per month	1 or 2 per month	1 per week	2 or 3 per week	4 to 6 per week	1 per day	2 or 3 per day	4 or more per day
3.1 Reading or viewing romantic or erotic books or stories	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
3.2 Masturbation	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
3.3 Casual kissing and petting	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
3.4 Sexual foreplay	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
3.5 Sexual intercourse, oral sex, etc.	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈

Section 4—Orgasm

During the past 30 days or since the last time you filled out this inventory, how satisfied have you been with the following?	Not at all	Slightly	Moderately	Highly	Extremely
4.1 Your ability to have an orgasm	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
4.2 The intensity of your orgasm	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
4.3 The ability to have multiple orgasms (if typical for you)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
4.4 Feelings of closeness and togetherness with your partner	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
4.5 Your sense of control (timing) of your orgasm	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
4.6 Feeling a sense of relaxation and well-being after orgasm	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

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Derogatis Interview for Sexual Function (DISF-SR) (F) Female Version (continued)

Section 5—Drive and Relationship

	Not at all	Less than 1 per month	1 or 2 per month	1 per week	2 or 3 per week	4 to 6 per week	1 per day	2 or 3 per day	4 or more per day
5.1 With the partner of your choice, what would be your ideal frequency of sexual intercourse?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
	Not at all	Slightly	Moderately	Highly	Extremely				
5.2 During this period, how interested have you been in sex?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄				
5.3 During this period, how satisfied have you been with your personal relationship with your sexual partner?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄				
	Could not be worse	Very poor	Poor	Somewhat inadequate	Adequate	Above average	Good	Very good	Could not be better
5.4 In general, what would represent the best description of the quality of your sexual functioning?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈

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Derogatis Interview for Sexual Function (DISF-SR) (M) Male Version

Instruction: Below you will find a brief set of questions about your sexual activities. The questions are divided into different sections that ask about different aspects of your sexual experiences. One section asks about **sexual fantasies** or daydreams, while another inquires about the kinds of **sexual experiences** that you have. You are also asked about the nature of your **sexual arousal** and the quality of your **orgasm**. There are also a few other questions about different areas of your sexual relationship.

On some questions you are asked to respond in terms of a frequency scale, that is, "how often" do you perform the sexual activities asked about in that section. Some frequency scales go from "0 = not at all" to "8 = four or more times a day." Other frequency scales range from "0 = never" to "4 = always." In the case of other questions, you will be asked to respond in terms of a satisfaction scale. This type of scale tells how much you enjoyed, or were satisfied by the sexual activity being asked about. Some satisfaction scales range from "0 = could not be worse" to "8 = could not be better." Other satisfaction scales go from "0 = not at all satisfied," to "4 = extremely satisfied."

In every section of the inventory the scales required for that section are printed just above the questions so it will be easy to follow. Although it is brief, take your time with the inventory. **For each item, please check the scale number that best describes your personal experience.**

If you have any questions, please ask the person who gave you the inventory for help.

Section 1—Sexual Cognition/Fantasy

During the past 30 days or since the last time you filled out this inventory, how often have you had thoughts, dreams, or fantasies about:	Not at all	Less than 1 per month	1 or 2 per month	1 per week	2 or 3 per week	4 to 6 per week	1 per day	2 or 3 per day	4 or more per day
1.1 A sexually attractive person	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
1.2 Erotic parts of a woman's body (e.g., face, genitals, legs)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
1.3 Erotic or romantic situations	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
1.4 Caressing, touching, undressing, or foreplay	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
1.5 Sexual intercourse, oral sex, touching to orgasm	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈

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Derogatis Interview for Sexual Function (DISF-SR) (M) Male Version (continued)

Section 2—Sexual Arousal

During the past 30 days or since the last time you filled out this inventory, how often did you have the following experiences?	Not at all	Less than 1 per month	1 or 2 per month	1 per week	2 or 3 per week	4 to 6 per week	1 per day	2 or 3 per day	4 or more per day
2.1 A full erection upon awakening	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
2.2 A full erection during a sexual fantasy or daydream	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
2.3 A full erection while looking at a sexually arousing person, movie, or picture	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
2.4 A full erection during masturbation	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
2.5 A full erection throughout the phases of a normal sexual response cycle, that is from undressing and foreplay through intercourse and orgasm	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈

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Derogatis Interview for Sexual Function (DISF-SR) (M) Male Version (continued)

Section 3—Sexual Behavior/Experiences

During the past 30 days or since the last time you filled out the inventory, how often did you engage in the following sexual activities?	Not at all	Less than 1 per month	1 or 2 per month	1 per week	2 or 3 per week	4 to 6 per week	1 per day	2 or 3 per day	4 or more per day
3.1 Reading or viewing romantic or erotic books or stories	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4	<input type="checkbox"/> _5	<input type="checkbox"/> _6	<input type="checkbox"/> _7	<input type="checkbox"/> _8
3.2 Masturbation	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4	<input type="checkbox"/> _5	<input type="checkbox"/> _6	<input type="checkbox"/> _7	<input type="checkbox"/> _8
3.3 Casual kissing and petting	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4	<input type="checkbox"/> _5	<input type="checkbox"/> _6	<input type="checkbox"/> _7	<input type="checkbox"/> _8
3.4 Sexual foreplay	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4	<input type="checkbox"/> _5	<input type="checkbox"/> _6	<input type="checkbox"/> _7	<input type="checkbox"/> _8
3.5 Sexual intercourse, oral sex, etc.	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4	<input type="checkbox"/> _5	<input type="checkbox"/> _6	<input type="checkbox"/> _7	<input type="checkbox"/> _8

Section 4—Orgasm

During the past 30 days or since the last time you filled out this inventory, how satisfied have you been with the following?	Not at all	Slightly	Moderately	Highly	Extremely
4.1 Your ability to have an orgasm	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
4.2 The intensity of your orgasm	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
4.3 The length or duration of your orgasm	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
4.4 The amount of seminal liquid that you ejaculate	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
4.5 Your sense of control (timing) of your orgasm	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
4.6 Feeling a sense of relaxation and well-being after orgasm	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4

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Section 5—Drive and Relationship

	Not at all	Less than 1 per month	1 or 2 per month	1 per week	2 or 3 per week	4 to 6 per week	1 per day	2 or 3 per day	4 or more per day
5.1 With the partner of your choice, what would be your ideal frequency of sexual intercourse?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
	Not at all	Slightly	Moderately	Highly	Extremely				
5.2 During this period, how interested have you been in sex?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄				
5.3 During this period, how satisfied have you been with your personal relationship with your sexual partner?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄				
	Could not be worse	Very poor	Poor	Somewhat inadequate	Adequate	Above average	Good	Very good	Could not be better
5.4 In general, what would represent the best description of the quality of your sexual functioning?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈

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Food Cravings Questionnaire—State (FCQ—S)

Below is a list of comments made by people about their eating habits. Please check one answer for each comment that indicates how much you agree with the comment **right now, at this very moment**. Notice that some questions refer to foods in general while others refer to one or more specific foods. Please respond to each item as honestly as possible.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1 I have an intense desire to eat [one or more specific foods].	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
2 I'm craving [one or more specific foods].	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
3 I have an urge for [one or more specific foods]	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
4 Eating [one or more specific foods] would make things seem just perfect.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
5 If I were to eat what I am craving, I am sure my mood would improve.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
6 Eating [one or more specific foods] would feel wonderful.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
7 If I ate something, I wouldn't feel so sluggish and lethargic.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
8 Satisfying my craving would make me feel less grouchy and irritable.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
9 I would feel more alert if I could satisfy my craving.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
10 If I had [one or more specific foods], I could not stop eating it.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
11 My desire to eat [one or more specific foods] seems overpowering.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
12 I know I'm going to keep on thinking about [one or more specific foods] until I actually have it.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
13 I am hungry.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
14 If I ate right now, my stomach wouldn't feel as empty.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
15 I feel weak because of not eating.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

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Food Craving Inventory (FCI-II)

For each of the foods listed below, please check the appropriate box.

Note: A craving is defined as an intense desire to consume a particular food or food type that is difficult to resist.

Over the past month, how often have you experienced a craving for...	Never	Rarely (once or twice)	Sometimes	Often	Always/Almost Every Day
1 Cake	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
2 Pizza	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
3 Fried chicken	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
4 Gravy	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
5 Sandwich bread	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
6 Sausage	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
7 French fries	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
8 Cinnamon rolls	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
9 Rice	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
10 Hot dog	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
11 Hamburger	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
12 Biscuits	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
13 Ice cream	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
14 Pasta	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
15 Fried fish	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
16 Cookies	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
17 Chocolate	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
18 Pancakes or waffles	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
19 Corn bread	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
20 Chips	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
21 Rolls	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
22 Cereal	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
23 Donuts	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
24 Candy	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
25 Brownies	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
26 Bacon	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
27 Steak	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
28 Baked potato	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

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Eating Inventory

- | | | | |
|----|--|-------------------------------|--------------------------------|
| 1 | When I smell a sizzling steak or see a juicy piece of meat, I find it very difficult to keep from eating, even if I have just finished a meal. | <input type="checkbox"/> True | <input type="checkbox"/> False |
| 2 | I usually eat too much at social occasions, like parties and picnics. | <input type="checkbox"/> True | <input type="checkbox"/> False |
| 3 | I am usually so hungry that I eat more than three times a day. | <input type="checkbox"/> True | <input type="checkbox"/> False |
| 4 | When I have eaten my quota of calories, I am usually good about not eating anymore. | <input type="checkbox"/> True | <input type="checkbox"/> False |
| 5 | Dieting is so hard for me because I just get too hungry. | <input type="checkbox"/> True | <input type="checkbox"/> False |
| 6 | I deliberately take small helpings as a means of controlling my weight. | <input type="checkbox"/> True | <input type="checkbox"/> False |
| 7 | Sometimes things just taste so good that I keep on eating even when I am no longer hungry. | <input type="checkbox"/> True | <input type="checkbox"/> False |
| 8 | Since I am often hungry, I sometimes wish that while I am eating, an expert would tell me that I have had enough or that I can have something more to eat. | <input type="checkbox"/> True | <input type="checkbox"/> False |
| 9 | When I feel anxious, I find myself eating. | <input type="checkbox"/> True | <input type="checkbox"/> False |
| 10 | Life is too short to worry about dieting. | <input type="checkbox"/> True | <input type="checkbox"/> False |
| 11 | Since my weight goes up and down, I have gone on reducing diets more than once. | <input type="checkbox"/> True | <input type="checkbox"/> False |
| 12 | I often feel so hungry that I just have to eat something. | <input type="checkbox"/> True | <input type="checkbox"/> False |
| 13 | When I am with someone who is overeating, I usually overeat too. | <input type="checkbox"/> True | <input type="checkbox"/> False |
| 14 | I have a pretty good idea of the number of calories in common food. | <input type="checkbox"/> True | <input type="checkbox"/> False |
| 15 | Sometimes when I start eating, I just can't seem to stop. | <input type="checkbox"/> True | <input type="checkbox"/> False |
| 16 | It is not difficult for me to leave something on my plate. | <input type="checkbox"/> True | <input type="checkbox"/> False |
| 17 | At certain times of the day, I get hungry because I have gotten used to eating then. | <input type="checkbox"/> True | <input type="checkbox"/> False |
| 18 | While on a diet, if I eat food that is not allowed, I consciously eat less for a period of time to make up for it. | <input type="checkbox"/> True | <input type="checkbox"/> False |

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Eating Inventory (continued)

- 19 Being with someone who is eating often makes me hungry to eat also. True False
- 20 When I feel blue, I often overeat. True False
- 21 I enjoy eating too much to spoil it by counting calories or watching my weight. True False
- 22 When I see a real delicacy, I often get so hungry that I have to eat right away. True False
- 23 I often stop eating when I am not really full as a conscious means of limiting the amount I eat. True False
- 24 I get so hungry that my stomach often seems like a bottomless pit. True False
- 25 My weight has hardly changed at all in the last ten years. True False
- 26 I am always hungry so it is hard for me to stop eating before I finish the food on my plate. True False
- 27 When I feel lonely, I console myself by eating. True False
- 28 I consciously hold back at meals in order not to gain weight. True False
- 29 I sometimes get very hungry late in the evening or at night. True False
- 30 I eat anything I want, any time I want. True False
- 31 Without even thinking about it, I take a long time to eat. True False
- 32 I count calories as a conscious means of controlling my weight. True False
- 33 I do not eat some foods because they make me fat. True False
- 34 I am always hungry enough to eat at any time. True False
- 35 I pay a great deal of attention to changes in my figure. True False
- 36 While on a diet, if I eat a food that is not allowed, I often splurge and eat other high calorie foods. True False

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Eating Inventory (continued)

Please check one answer that is most appropriate to you for each question below.

37	How often are you dieting in a conscious effort to control your weight?	<input type="checkbox"/> ₁ Rarely	<input type="checkbox"/> ₂ Sometimes	<input type="checkbox"/> ₃ Usually	<input type="checkbox"/> ₄ Always		
38	Would a weight fluctuation of 5 pounds affect the way you live your life?	<input type="checkbox"/> ₁ Rarely	<input type="checkbox"/> ₂ Sometimes	<input type="checkbox"/> ₃ Usually	<input type="checkbox"/> ₄ Always		
39	How often do you feel hungry?	<input type="checkbox"/> ₁ Rarely	<input type="checkbox"/> ₂ Sometimes	<input type="checkbox"/> ₃ Usually	<input type="checkbox"/> ₄ Always		
40	Do your feelings of guilt about overeating help you to control your food intake?	<input type="checkbox"/> ₁ Rarely	<input type="checkbox"/> ₂ Sometimes	<input type="checkbox"/> ₃ Usually	<input type="checkbox"/> ₄ Always		
41	How difficult would it be for you to stop eating halfway through dinner and not eat for the next four hours?	<input type="checkbox"/> ₁ Easy	<input type="checkbox"/> ₂ Slightly difficult	<input type="checkbox"/> ₃ Moderately difficult	<input type="checkbox"/> ₄ Very difficult		
42	How conscious are you of what you are eating?	<input type="checkbox"/> ₁ Not at all	<input type="checkbox"/> ₂ Slightly	<input type="checkbox"/> ₃ Moderately	<input type="checkbox"/> ₄ Extremely		
43	How frequently do you avoid "stocking up" on tempting foods?	<input type="checkbox"/> ₁ Almost never	<input type="checkbox"/> ₂ Seldom	<input type="checkbox"/> ₃ Usually	<input type="checkbox"/> ₄ Almost always		
44	How likely are you to shop for low calorie foods?	<input type="checkbox"/> ₁ Unlikely	<input type="checkbox"/> ₂ Slightly likely	<input type="checkbox"/> ₃ Moderately likely	<input type="checkbox"/> ₄ Very likely		
45	Do you eat sensibly in front of others and splurge alone?	<input type="checkbox"/> ₁ Never	<input type="checkbox"/> ₂ Rarely	<input type="checkbox"/> ₃ Often	<input type="checkbox"/> ₄ Always		
46	How likely are you to consciously eat slowly in order to cut down on how much you eat?	<input type="checkbox"/> ₁ Unlikely	<input type="checkbox"/> ₂ Slightly likely	<input type="checkbox"/> ₃ Moderately likely	<input type="checkbox"/> ₄ Very likely		
47	How frequently do you skip dessert because you are no longer hungry?	<input type="checkbox"/> ₁ Almost never	<input type="checkbox"/> ₂ Seldom	<input type="checkbox"/> ₃ At least once a week	<input type="checkbox"/> ₄ Almost every day		
48	How likely are you to consciously eat less than you want?	<input type="checkbox"/> ₁ Unlikely	<input type="checkbox"/> ₂ Slightly likely	<input type="checkbox"/> ₃ Moderately likely	<input type="checkbox"/> ₄ Very likely		
49	Do you go on eating binges though you are not hungry?	<input type="checkbox"/> ₁ Never	<input type="checkbox"/> ₂ Rarely	<input type="checkbox"/> ₃ Sometimes	<input type="checkbox"/> ₄ At least once a week		
50	To what extent does this statement describe your eating behavior? "I start dieting in the morning, but because of any number of things that happen during the day, by evening I have given up and eat what I want, promising myself to start dieting again tomorrow."	<input type="checkbox"/> ₁ Not like me	<input type="checkbox"/> ₂ Little like me	<input type="checkbox"/> ₃ Pretty good description of me	<input type="checkbox"/> ₄ Describes me perfectly		
51	On a scale of 0 to 5, where 0 means no restraint in eating (eating whatever you want, whenever you want it) and 5 means total restraint (constantly limiting food intake and never "giving in"), what number would you give yourself?	<input type="checkbox"/> ₀ Eat whatever you want, whenever you want it	<input type="checkbox"/> ₁ Usually eat whatever you want, whenever you want it	<input type="checkbox"/> ₂ Often eat whatever you want, whenever you want it	<input type="checkbox"/> ₃ Often limit food intake, but often "give in"	<input type="checkbox"/> ₄ Usually limit food intake, rarely "give in"	<input type="checkbox"/> ₅ Constantly limiting food intake, never "giving in"

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day month year

Weight Efficacy Lifestyle Questionnaire (WEL)

This form describes some typical eating situations. Everyone has situations which make it very hard for them to keep their weight down. The following are a number of situations relating to eating patterns and attitudes. This form will help you to identify the eating situations which you find the hardest to manage.

Read each situation listed below and decide how confident (or certain) you are that you will be able to resist eating in each of the difficult situations. In other words, pretend that you are in the eating situation right now. On a scale from 0 (not confident) to 9 (very confident), choose ONE number that reflects how confident you feel now about being able to **successfully resist** the desire to eat. Check this number for each item.

I am confident that:	Not confident at all that you can resist the desire to eat					Very confident that you can resist the desire to eat				
	0	1	2	3	4	5	6	7	8	9
1 I can resist eating when I am anxious (nervous).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 I can control my eating on the weekends.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 I can resist eating even when I have to say "no" to others.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 I can resist eating when I feel physically run down.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 I can resist eating when I am watching TV.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 I can resist eating when I am depressed (or down).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7 I can resist eating when there are many different kinds of food available.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8 I can resist eating even when I feel it is impolite to refuse a second helping.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9 I can resist eating even when I have a headache.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

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Weight Efficacy Lifestyle Questionnaire (WEL) (continued)

I am confident that:	Not confident at all that you can resist the desire to eat					Very confident that you can resist the desire to eat				
	0	1	2	3	4	5	6	7	8	9
10 I can resist eating when I am reading.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 I can resist eating when I am angry (or irritable).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12 I can resist eating even when I am at a party.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13 I can resist eating even when others are pressuring me to eat.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14 I can resist eating when I am in pain.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15 I can resist eating just before going to bed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16 I can resist eating when I have experienced failure.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17 I can resist eating when high-calorie foods are available.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18 I can resist eating even when I think others will be upset if I don't eat.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19 I can resist eating when I feel uncomfortable.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20 I can resist eating when I am happy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Multiaxial Assessment of Eating Disorder Symptoms (MAEDS)

Instructions: Using the scale shown, please rate the following items on a scale from 1 to 7. Please answer as truthfully as possible.

	Never	Very Rarely	Rarely	Sometimes	Often	Very Often	Always
1 Fasting is a good way to lose weight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
2 My sleep isn't as good as it used to be.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
3 I avoid eating for as long as I can.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
4 Certain foods are "forbidden" for me to eat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
5 I can't keep certain foods in my house because I will binge on them.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
6 I can easily make myself vomit.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
7 I can feel that being fat is terrible.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
8 I avoid greasy foods.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
9 It's okay to binge and purge once in a while.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
10 I don't eat certain foods.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
11 I think I am a good person.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
12 My eating is normal.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
13 I can't seem to concentrate lately.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
14 I try to diet by fasting.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
15 I vomit to control my weight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
16 Lately nothing seems enjoyable anymore.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
17 Laxatives help keep you slim.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
18 I don't eat red meat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
19 I eat so rapidly I can't even taste my food.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

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Multiaxial Assessment of Eating Disorder Symptoms (MAEDS) (continued)

	Never	Very Rarely	Rarely	Some-times	Often	Very Often	Always
20 I do everything I can to avoid being overweight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
21 When I feel bloated, I must do something to rid myself of that feeling.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
22 I overeat too frequently.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
23 It's okay to be overweight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
24 Recently I have felt that I am a worthless person.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
25 I would be very upset if I gained 2 pounds.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
26 I crave sweets and carbohydrates.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
27 I lose control when I eat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
28 Being fat would be terrible.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
29 I have thought seriously about suicide lately.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
30 I don't have any energy anymore.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
31 I eat small portions to control my weight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
32 I eat 3 meals a day.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
33 Lately I have been easily irritated.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
34 Some foods should be totally avoided.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
35 I use laxatives to control my weight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
36 I am terrified by the thought of being overweight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
37 Purging is a good way to lose weight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
38 I avoid fatty foods.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇

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Multiaxial Assessment of Eating Disorder Symptoms (MAEDS) (continued)

	Never	Very Rarely	Rarely	Some-times	Often	Very Often	Always
39 Recently I have felt pretty blue.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
40 I am obsessed with becoming overweight.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
41 I don't eat fried foods.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
42 I skip meals.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
43 Fat people are unhappy.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
44 People are too concerned with the way I eat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
45 I feel good when I skip meals.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
46 I avoid foods with sugar.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
47 I hate it when I feel fat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
48 I am too fat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
49 I eat until I am completely stuffed.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
50 I hate to eat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
51 I feel guilty about a lot of things these days.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
52 I'm very careful of what I eat.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
53 I can "hold off" and not eat even if I am hungry.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
54 I eat even when I am not hungry.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
55 Fat people are disgusting.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
56 I wouldn't mind gaining a few pounds.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇

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day month year

Body Shape Questionnaire (BSQ)

We would like to know how you have been feeling about your appearance over the **past four weeks**. Please read each question and check the box for the appropriate choice. Please answer all the questions.

Over the Past Four Weeks...	Never	Rarely	Sometimes	Often	Very Often	Always
1 Has feeling bored made you brood about your shape?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
2 Have you been so worried about your shape that you have been feeling that you ought to diet?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
3 Have you thought that your thighs, hips, or bottom are too large for the rest of you?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
4 Have you been afraid that you might become fat (or fatter)?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
5 Have you worried about your flesh not being firm enough?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
6 Has feeling full (e.g., after eating a large meal) made you feel fat?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
7 Have you felt so bad about your shape that you have cried?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
8 Have you avoided running because your flesh might wobble?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
9 Has being with thin women/men made you feel self-conscious about your shape?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
10 Have you worried about your thighs spreading out when sitting down?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
11 Has eating even a small amount of food made you feel fat?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
12 Have you noticed the shape of other women/men and felt that your own shape compared unfavorably?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
13 Has thinking about your shape interfered with your ability to concentrate (e.g., while watching TV, reading, listening to conversations)?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
14 Has being naked, such as when taking a bath, made you feel fat?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
15 Have you avoided wearing clothes which make you particularly aware of the shape of your body?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
16 Have you imagined cutting off fleshy areas of your body?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Participant's Initials: _____
first middle last

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Center Number: ____ Participant Number: ____ Participant's Initials: ____
first middle last

Body Shape Questionnaire (BSQ) (continued)

Over the Past Four Weeks...	Never	Rarely	Some- times	Often	Very Often	Always
17 Has eating sweets, cakes or other high calorie food made you feel fat?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
18 Have you not gone out on social occasions (e.g., parties) because you have felt bad about your shape?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
19 Have you felt excessively large and rounded?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
20 Have you felt ashamed of your body?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
21 Has worry about your shape made you diet?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
22 Have you felt happiest about your shape when your stomach has been empty?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
23 Have you thought that you are the shape you are because you lack self-control?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
24 Have you worried about other people seeing rolls of flesh around your waist or stomach?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
25 Have you felt that it is not fair that other women/men are thinner than you?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
26 Have you vomited in order to feel thinner?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
27 When in company, have you worried about taking up too much room (e.g., sitting on a sofa or bus seat)?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
28 Have you worried about your flesh being dimply?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
29 Has seeing your reflection (e.g., in a mirror or shop window) made you feel bad about your shape?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
30 Have you pinched areas of your body to see how much fat is there?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
31 Have you avoided situations where people could see your body (e.g., communal changing rooms or swimming pools)?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
32 Have you taken laxatives in order to feel thinner?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
33 Have you been particularly self-conscious about your shape when in the company of other people?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
34 Has worry about your shape made you feel you ought to exercise?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆

Participant's Initials: ____
first middle last

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Center Number: ____ Participant Number: ____ Participant's Initials: first middle last ____

Handgrip Strength

Date and time of assessment: ____/____/____ 00:00 to 23:59
day month year

Staff initials: first middle last ____

OR Not done → Specify reason (use codelist below): ____

1 Dynamometer handle position: _____

2 Dominant hand (check only one): ₁ Left ₂ Right ₃ Ambidextrous

3 Handgrip strength:

Handgrip Strength	Zero Meter Check	Right Hand	Zero Meter Check	Left Hand
Test 1—peak force	<input type="checkbox"/> ₀	_____ kg	<input type="checkbox"/> ₀	_____ kg
Test 2—peak force	<input type="checkbox"/> ₀	_____ kg	<input type="checkbox"/> ₀	_____ kg
Test 3—peak force	<input type="checkbox"/> ₀	_____ kg	<input type="checkbox"/> ₀	_____ kg

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Isometric/Isokinetic Knee Extension and Flexion

Date and time of assessment: ____/____/____ :____:____
day month year 00:00 to 23:59

Staff initials: _____
first middle last

OR Not done → Specify reason (use codelist below): _____

- 1** Recent injury or pain—right knee? ₀ No ₁ Yes
- 2** Recent injury or pain—left knee? ₀ No ₁ Yes
- 3** Specify machine used (PBRC only): ₀ Cybex ₁ Biolex

All values corrected for gravity effect torque		Right Leg	Left Leg	If Not Done, Specify Reason (Use codelist below)
3 60°/sec knee extension	peak torque	_____ N.m	_____ N.m	_____
	total work	_____ N.m	_____ N.m	
	average power	_____ watts	_____ watts	
4 60°/sec knee flexion	peak torque	_____ N.m	_____ N.m	_____
	total work	_____ N.m	_____ N.m	
	average power	_____ watts	_____ watts	
5 180°/sec knee extension	peak torque	_____ N.m	_____ N.m	_____
	total work	_____ N.m	_____ N.m	
	average power	_____ watts	_____ watts	
	work fatigue index	_____ %	_____ %	
6 180°/sec knee flexion	peak torque	_____ N.m	_____ N.m	_____
	total work	_____ N.m	_____ N.m	
	average power	_____ watts	_____ watts	
	work fatigue index	_____ %	_____ %	
7 Isometric knee extension: trial 1	peak torque	_____ N.m	_____ N.m	_____
	trial 2 peak torque	_____ N.m	_____ N.m	
	trial 3 peak torque	_____ N.m	_____ N.m	
8 Isometric knee flexion: trial 1	peak torque	_____ N.m	_____ N.m	_____
	trial 2 peak torque	_____ N.m	_____ N.m	
	trial 3 peak torque	_____ N.m	_____ N.m	

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: ____ Participant Number: ____ Participant's Initials: first middle last ____

Clinic Weight

Weight date and time: ____/____/____ : ____
day month year 00:00 to 23:59

Staff initials: first middle last ____

OR Not done → Specify reason (use codelist below): ____

Clinic weight (if the two measurements are more than 0.1 kg apart, measure weight a third time):

Weight 1: ____ . ____ kg

Weight 2: ____ . ____ kg

Weight 3: ____ . ____ kg

Weight of gown: ____ . ____ kg

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Seven-Day Physical Activity Recall (PAR)

Today's date: ____/____/____ Day (check only one): Mon Tues Wed Thurs Fri Sat Sun OR Not done → Specify reason (use codelist below): _____

1 Were you employed in the last seven days? No → Skip to question 3 Yes
 Interviewer initials: _____
first middle last

2 If Yes: Which days (check all that apply)?
 Mon Tues Wed Thurs Fri Sat Sun

3 Which days do you consider your weekend, or non-work, days?
 Mon Tues Wed Thurs Fri Sat Sun

Day #	Day of Week	Date	Sleep Time			Work Time			Morning (in minutes)			Afternoon (in minutes)			Evening (in minutes)		
			In Bed	Up		Start	Stop		Mod.	Hard	Very Hard	Mod.	Hard	Very Hard	Mod.	Hard	Very Hard
7	(yester- day)	____/____/____ <small>day month year</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>
6		____/____/____ <small>day month year</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>
5		____/____/____ <small>day month year</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>
4		____/____/____ <small>day month year</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>
3		____/____/____ <small>day month year</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>
2		____/____/____ <small>day month year</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>
1	(1 week ago)	____/____/____ <small>day month year</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>	____:____ to ____:____ <small>00:00 to 23:59</small>

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: ____ Participant Number: ____ Participant's Initials: first middle last ____

Seven-Day Physical Activity Recall (PAR) (continued)

4 Compared to your physical activity over the past three months, was last week's physical activity more, less, or about the same (check only one)?

- ₁ More
₂ Less
₃ About the same

Interviewer: Please answer questions below and note any comments on interview.

5 Were there any problems with the Seven-Day PAR interview?

- ₀ No
₁ Yes

6 Do you think this was a valid Seven-Day PAR interview?

- ₀ No
₁ Yes

7 Were there any activities reported by the participant that you don't know how to classify?

- ₀ No
₁ Yes

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

6-Day Food Record

Complete below OR Not done → Specify reason (use Codelist below): _____

Staff initials: _____
first middle last

			Replacement Values		
Day of DLW	Date of Record	Record Quality (check only one)	Day of DLW	Date of Record	Record Quality (check only one)
1	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing	8	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing
2	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing	9	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing
3	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing	10	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing
4	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing	11	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing
5	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing	12	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing
6	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing	13	____/____/____ <small>day month year</small>	<input type="checkbox"/> 1 Reliable <input type="checkbox"/> 2 Unreliable <input type="checkbox"/> 3 Missing

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

VO₂ Max

1 Date and time of test: ____/____/____ year ____:____
day month year 00:00 to 23:59 **Staff initials:** _____
first middle last

OR Not done → Specify reason (use codelist below): _____

2 At what time was the participant's last meal/snack eaten? ____:____
00:00 to 23:59

3 Rest ECG: Rhythm (check only one): ₁ Sinus ₂ Atrial fibrillation ₉₈ Other
Ventricular conduction (check only one): ₁ Normal ₂ LBBB ₃ RBBB

4 Heart rate (HR) data: Resting heart rate: _____ bpm
 Age-predicted heart rate: _____ bpm
 Heart rate (max): _____ bpm

5 Reason(s) for termination of testing (check all that apply):

- Symptom limited (dyspnea, fatigue)
- Angina/ischemia → **Complete all that apply:** HR when true cardiac angina occurred: _____ bpm OR ₉₆ NA
 HR when ischemic ECG changes occurred: _____ bpm OR ₉₆ NA
- Serious arrhythmias (VT or SVT)
- Changes in blood pressure
- Ventricular ischemia (schedule stress image study, complete ventricular episode report)
- Orthopedic/extremity complaints (pains/cramps)
- Other (specify): _____

6 Did frequent ventricular ectopy occur (e.g., ≥ 7 PVCs/min, bi/tri-geminy, NSVT [≥ 3 beats])?

- ₀ No
- ₁ Yes → **If Yes: When did it occur (check all that apply)?** During exercise During recovery

7 Peak VO₂: _____ mL/kg/min _____ L/min

8 Did the participant meet at least 2 of the 3 VO₂ max criteria (see box, right)?

- ₀ No
- ₁ Yes → **If Yes: VO₂ max:** _____ mL/kg/min _____ L/min

a Achieve a plateau in VO₂ (change ≤ 150 mL between the final two stages)
 b RER ≥ 1.1
 c HR max ± 5 bpm of age-predicted maximum

9 Exercise time: ____:____
minutes seconds

10 Blood pressure at VO₂ peak/VO₂ max: ____/____ mm Hg
systolic diastolic

11 Borg RPE score at VO₂ peak/VO₂ max: _____ (6-20)

12 Peak RER: _____

13 VE at VO₂ peak/VO₂ max: _____ L/min

14 VE/VO₂ at VO₂ peak/VO₂ max _____ L/min

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Outcomes Labs

Date and time sample collection started: _____ / _____ / _____ : _____
day month year 00:00 to 23:59

Sample <i>If a sample is not obtained, indicate with a Not Done.</i>	Sample Complete?	If Not Done, Reason <i>(Use codelist below)</i>	Staff Initials
Blood	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	_____ <small>first middle last</small>

Core Temperature

Staff Initials	Provide Date of Sample Collection/Procedure	Time of Sample Collection/Procedure	If Not Done, Reason <i>(Use codelist below)</i>
_____ <small>first middle last</small>	Start Date: _____ / _____ / _____ <small>day month year</small>	Start Time _____ : _____ <small>00:00 to 23:59</small>	_____
	Stop Date: _____ / _____ / _____ <small>day month year</small>	Stop Time _____ : _____ <small>00:00 to 23:59</small>	

Inpatient Admission and Discharge

1 Inpatient admission date and time: _____ / _____ / _____ : _____
day month year 00:00 to 23:59

2 Inpatient discharge date and time: _____ / _____ / _____ : _____
day month year 00:00 to 23:59

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: _____ Participant Number: _____ Participant's Initials:
first middle last

Delayed-type Hypersensitivity (DTH)

1 Was the DTH worksheet completed?

₀ No

₁ Yes → If Yes: Were any Exclusion criteria met? ₀ No → Proceed with test

₁ Yes → STOP. Do not administer test.

2 Date of injection: / / day month year OR Not done → Specify reason (use codelist below): _____

3 Injection by (initials):
first middle last

4 Arm injected: ₁ Right ₂ Left

5 DTH results:

Note: For each reaction, measure two diameters in millimeters (mm). The first diameter is called the maximum diameter because the induration may not be in the shape of a circle. If the induration is an oval shape, first measure the long diameter and then the diameter perpendicular to it. Do not measure erythema. Reaction is considered positive if the average diameter is equal to or greater than 5 mm.

A = Largest diameter

B = Second diameter perpendicular to A

Antigen	24 Hour (@ Visit 4)			48 Hour (@ Visit 5)		
	A (diameter)	B (diameter)	Read By:	A (diameter)	B (diameter)	Read By:
1 Normal saline	_____ mm	_____ mm	<u> </u> <u> </u> <u> </u> <small>first middle last</small> (initials)	_____ mm	_____ mm	<u> </u> <u> </u> <u> </u> <small>first middle last</small> (initials)
2 Tetanus toxoid (TT)	_____ mm	_____ mm		_____ mm	_____ mm	
3 Candida	_____ mm	_____ mm		_____ mm	_____ mm	
4 Trichophyton	_____ mm	_____ mm		_____ mm	_____ mm	

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Clinic Weight

Weight date and time: _____/_____/_____ : _____
day month year 00:00 to 23:59

Staff initials: _____
first middle last

OR Not done → Specify reason (use codelist below): _____

Clinic weight (if the two measurements are more than 0.1 kg apart, measure weight a third time):

Weight 1: _____ . _____ kg

Weight 2: _____ . _____ kg

Weight 3: _____ . _____ kg

Weight of gown: _____ . _____ kg

Outcomes Labs

Date and time of last meal: _____/_____/_____ : _____
day month year 00:00 to 23:59

Date and time sample collection started: _____/_____/_____ : _____
day month year 00:00 to 23:59

Sample	Sample Complete?	If Not Done, Reason (Use codelist below)	Staff Initials
Catecholamines	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	_____	_____ <small>first middle last</small>
Blood	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	_____	_____ <small>first middle last</small>
Oral glucose tolerance test (OGTT)	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	_____	_____ <small>first middle last</small>

If a sample is not obtained, indicate with a Not Done.

24-hour Urine Collection

Total Volume Collected	Date of Sample Collection	Time of Sample Collection	If Not Done, Reason (Use codelist below)	Staff Initials
_____ mL	<p>Start Date:</p> <p>_____/_____/_____</p> <p><small>day month year</small></p> <p>Stop Date:</p> <p>_____/_____/_____</p> <p><small>day month year</small></p>	<p>Start Time:</p> <p>_____:_____</p> <p><small>00:00 to 23:59</small></p> <p>Stop Time:</p> <p>_____:_____</p> <p><small>00:00 to 23:59</small></p>	_____	_____ <small>first middle last</small>

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

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Center Number: ____ Participant Number: ____ Participant's Initials:
first middle last

Sex Hormone

If Not Done → Specify reason (use codelist below): _____

Contraception method (females only):

None OR Check all that apply:

Oral contraceptive → Specify: _____

Record on Concomitant Medications page

Other → Specify (e.g., barrier, IUD): _____

Day 1	Date	Time	If Not Done, Reason (use codelist)	Staff Initials
Day 1 of menses (females only)				
Date and time of last meal (males only)	____/____/____ <small>day month year</small>	____:____ <small>00:00 to 23:59</small>		
Hormone level blood draw 1 (males only)	____/____/____ <small>day month year</small>	____:____ <small>00:00 to 23:59</small>	_____	<u> </u> <u> </u> <u> </u> <small>first middle last</small>
Hormone level blood draw 2 (females only) Progesterone level				
Day 2	Date	Time	If Not Done, Reason (use codelist)	Staff Initials
Date and time of last meal				
Hormone level blood draw 3 (females only) Progesterone level				

Metabolic Rate

Sample	Date of Collection	If Not Done, Reason (Use codelist below)	Staff Initials
Resting Metabolic Rate (RMR)—Visit 4	____/____/____ <small>day month year</small>	_____	<u> </u> <u> </u> <u> </u> <small>first middle last</small>
Cart ID	<input type="checkbox"/> Tufts-003 (623-002) <input type="checkbox"/> WASH U-001 (623-003) <input type="checkbox"/> PBRC-016 (623-005) <input type="checkbox"/> Tufts-006 (623-006) <input type="checkbox"/> WASH U-002 (623-004) <input type="checkbox"/> PBRC-017 (623-001)		

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Seven-Day Physical Activity Recall (PAR)

Today's date: ____/____/____ Day (check only one): Mon Tues Wed Thurs Fri Sat Sun OR Not done → Specify reason (use codelist below): _____

1 Were you employed in the last seven days? No → Skip to question 3 Yes

2 If Yes: Which days (check all that apply)? Mon Tues Wed Thurs Fri Sat Sun

3 Which days do you consider your weekend, or non-work, days? Mon Tues Wed Thurs Fri Sat Sun

Interviewer initials: _____
first middle last

Day #	Day of Week	Date	Sleep Time		Work Time		Morning (in minutes)			Afternoon (in minutes)			Evening (in minutes)					
			In Bed	Up	Start	Stop	Mod.	Hard	Very Hard	Mod.	Hard	Very Hard	Mod.	Hard	Very Hard			
7	(yesterday)	____/____/____ <small>day month year</small>	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59												
6		____/____/____ <small>day month year</small>	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59												
5		____/____/____ <small>day month year</small>	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59												
4		____/____/____ <small>day month year</small>	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59												
3		____/____/____ <small>day month year</small>	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59												
2		____/____/____ <small>day month year</small>	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59												
1	(1 week ago)	____/____/____ <small>day month year</small>	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59	00:00 to 23:59 : : 00:00 to 23:59												

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: ____ Participant Number: ____ Participant's Initials: first middle last ____

Seven-Day Physical Activity Recall (PAR) (continued)

4 Compared to your physical activity over the past three months, was last week's physical activity more, less, or about the same (check only one)?

- ₁ More
₂ Less
₃ About the same

Interviewer: Please answer questions below and note any comments on interview.

5 Were there any problems with the Seven-Day PAR interview?

- ₀ No
₁ Yes

6 Do you think this was a valid Seven-Day PAR interview?

- ₀ No
₁ Yes

7 Were there any activities reported by the participant that you don't know how to classify?

- ₀ No
₁ Yes

Center Number: ____ Participant Number: ____ Participant's Initials: first middle last

Biopsy Labs			
Sample	Date of Collection	If Not Done, Reason <i>(Use codelist below)</i>	Staff Initials
Muscle biopsy	____/____/____ <small>day month year</small>	_____	_____ <small>first middle last</small>
Fat biopsy	____/____/____ <small>day month year</small>	_____	_____ <small>first middle last</small>

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Signs, Symptoms and Adverse Events

Update form for each visit and mark corresponding additional box. Send copies of this form with each submission starting with baseline:

Baseline 1 Baseline 2 Month 1 Month 3 Month 6 Month 9 Month 12 Month 18 Month 24

AE #	Adverse Event	Serious	Intensity	Causality (check only one)	Action Taken Due to AE (check all that apply)	Outcome	Start/End Date OR Check if Continuing
—		<input type="checkbox"/> No <input type="checkbox"/> Yes*	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Doubtful <input type="checkbox"/> Possibly <input type="checkbox"/> Probably <input type="checkbox"/> Very likely	<input type="checkbox"/> None <input type="checkbox"/> Intervention temporarily discontinued <input type="checkbox"/> Medical therapy required <input type="checkbox"/> Intervention permanently discontinued <input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> Still present and unchanged <input type="checkbox"/> Improving <input type="checkbox"/> Resolved <input type="checkbox"/> Resolved with sequelae <input type="checkbox"/> Death	Start Date: ___/___/___ day month year End Date: ___/___/___ day month year OR <input type="checkbox"/> Continuing
—		<input type="checkbox"/> No <input type="checkbox"/> Yes*	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Doubtful <input type="checkbox"/> Possibly <input type="checkbox"/> Probably <input type="checkbox"/> Very likely	<input type="checkbox"/> None <input type="checkbox"/> Intervention temporarily discontinued <input type="checkbox"/> Medical therapy required <input type="checkbox"/> Intervention permanently discontinued <input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> Still present and unchanged <input type="checkbox"/> Improving <input type="checkbox"/> Resolved <input type="checkbox"/> Resolved with sequelae <input type="checkbox"/> Death	Start Date: ___/___/___ day month year End Date: ___/___/___ day month year OR <input type="checkbox"/> Continuing
—		<input type="checkbox"/> No <input type="checkbox"/> Yes*	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Doubtful <input type="checkbox"/> Possibly <input type="checkbox"/> Probably <input type="checkbox"/> Very likely	<input type="checkbox"/> None <input type="checkbox"/> Intervention temporarily discontinued <input type="checkbox"/> Medical therapy required <input type="checkbox"/> Intervention permanently discontinued <input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> Still present and unchanged <input type="checkbox"/> Improving <input type="checkbox"/> Resolved <input type="checkbox"/> Resolved with sequelae <input type="checkbox"/> Death	Start Date: ___/___/___ day month year End Date: ___/___/___ day month year OR <input type="checkbox"/> Continuing
—		<input type="checkbox"/> No <input type="checkbox"/> Yes*	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Doubtful <input type="checkbox"/> Possibly <input type="checkbox"/> Probably <input type="checkbox"/> Very likely	<input type="checkbox"/> None <input type="checkbox"/> Intervention temporarily discontinued <input type="checkbox"/> Medical therapy required <input type="checkbox"/> Intervention permanently discontinued <input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> Still present and unchanged <input type="checkbox"/> Improving <input type="checkbox"/> Resolved <input type="checkbox"/> Resolved with sequelae <input type="checkbox"/> Death	Start Date: ___/___/___ day month year End Date: ___/___/___ day month year OR <input type="checkbox"/> Continuing

* If Serious is Yes, submit expedited SAE form. **SAE Reporting Criteria:** **1** Death **2** Life threatening **3** Persistent or significant disability/incapacity **4** Prolonged or required hospitalization **5** Congenital anomaly or birth defect **6** Other significant medical event

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Concomitant Medications Log

Record any medications taken after start of baseline visit, including over-the-counter and prescription drugs, vitamins, supplements, and herbal medications. Update form for each visit and mark corresponding additional box.

Send copies of this form with each submission starting with baseline:

Baseline 1 Baseline 2 Month 1 Month 3 Month 6 Month 9 Month 12 Month 18 Month 24

Medication	Start Date or <input checked="" type="checkbox"/> if Pre-study	Stop Date or <input checked="" type="checkbox"/> if Continuing	Indication
1 Study vitamin-mineral supplement	____/____/____ <small>day month year</small>	____/____/____ <small>day month year</small>	
2 Study calcium supplement	____/____/____ <small>day month year</small>	____/____/____ <small>day month year</small>	
3	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Pre-study	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Continuing	
4	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Pre-study	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Continuing	
5	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Pre-study	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Continuing	
6	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Pre-study	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Continuing	
7	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Pre-study	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Continuing	
8	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Pre-study	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Continuing	
9	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Pre-study	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Continuing	
10	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Pre-study	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Continuing	
11	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Pre-study	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Continuing	
12	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Pre-study	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Continuing	

Center Number: ____ Participant Number: _____ Participant's Initials:
first middle last

Concomitant Medications Log

Record any medications taken after start of baseline visit, including over-the-counter and prescription drugs, vitamins, supplements, and herbal medications. Update form for each visit and mark corresponding additional box.

Send copies of this form with each submission starting with baseline:

Baseline 1 Baseline 2 Month 1 Month 3 Month 6 Month 9 Month 12 Month 18 Month 24

Medication	Start Date or <input checked="" type="checkbox"/> if Pre-study	Stop Date or <input checked="" type="checkbox"/> if Continuing	Indication
1	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Pre-study	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Continuing	
2	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Pre-study	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Continuing	
3	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Pre-study	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Continuing	
4	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Pre-study	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Continuing	
5	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Pre-study	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Continuing	
6	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Pre-study	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Continuing	
7	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Pre-study	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Continuing	
8	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Pre-study	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Continuing	
9	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Pre-study	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Continuing	
10	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Pre-study	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Continuing	
11	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Pre-study	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Continuing	
12	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Pre-study	____/____/____ <small>day month year</small> OR <input type="checkbox"/> Continuing	

Page Numbering: Sequentially number each page in the right hand corner, i.e. 281+1, 281+2, 281+3. Insert additional pages as needed.

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Serious Adverse Event Form

Report type: Initial
 Follow-up #: _____ Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

SAE Details:		Participant's Details:	
SAE Term (Medical Diagnosis): _____ SAE Onset Date: ____/____/____ <small>day month year</small> SAE Stop Date: ____/____/____ <small>day month year</small>		Date of birth: ____/____/____ <small>day month year</small> Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Serious Reporting Criteria: <i>(check all that apply)</i>	Causality & Intensity: <i>(check only one)</i>	Outcome (at time of report): <i>(check only one)</i>	
<input type="checkbox"/> Death <input type="checkbox"/> Life-threatening <input type="checkbox"/> Persistent or significant disability or incapacity <input type="checkbox"/> Prolonged or required hospitalization <input type="checkbox"/> Congenital anomaly or birth defect <input type="checkbox"/> Other significant event requiring medical and/or surgical intervention	Causality: <input type="checkbox"/> 1 None <input type="checkbox"/> 2 Doubtful <input type="checkbox"/> 3 Possibly <input type="checkbox"/> 4 Probably <input type="checkbox"/> 5 Very likely Intensity: <input type="checkbox"/> 1 Mild <input type="checkbox"/> 2 Moderate <input type="checkbox"/> 3 Severe	<input type="checkbox"/> 1 Still present and unchanged <input type="checkbox"/> 2 Improving <input type="checkbox"/> 3 Resolved <input type="checkbox"/> 4 Resolved with sequelae <input type="checkbox"/> 5 Death → If Death: Date of death: ____/____/____ <small>day month year</small>	
Action Taken with Study Intervention: <i>(check all that apply)</i>			
<input type="checkbox"/> None <input type="checkbox"/> Intervention temporarily discontinued → Complete and fax the Temporary Discontinuation from CR Intervention form <input type="checkbox"/> Medical therapy required <input type="checkbox"/> Intervention permanently discontinued → Complete and fax the Permanent Discontinuation from CR Intervention form <input type="checkbox"/> Other (specify): _____			

Notify DCRI Safety Surveillance of the SAE within 24 hours after your knowledge

Fax SAE form to DCRI Safety Surveillance at 1-919-668-7138 or 1-866-668-7138 within 24 hours of initial notification

Serious Adverse Event Form

Report type: Initial

Follow-up #: _____ Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Medical History (relevant to event):

Concomitant Medication (do not list medication administered to treat this event):

Medication	Dose & Unit	Frequency	Route	Start Date	Continued	Stop Date
				____/____/____ <small>day month year</small>	<input type="checkbox"/> No <input type="checkbox"/> Yes	____/____/____ <small>day month year</small>
				____/____/____ <small>day month year</small>	<input type="checkbox"/> No <input type="checkbox"/> Yes	____/____/____ <small>day month year</small>
				____/____/____ <small>day month year</small>	<input type="checkbox"/> No <input type="checkbox"/> Yes	____/____/____ <small>day month year</small>
				____/____/____ <small>day month year</small>	<input type="checkbox"/> No <input type="checkbox"/> Yes	____/____/____ <small>day month year</small>
				____/____/____ <small>day month year</small>	<input type="checkbox"/> No <input type="checkbox"/> Yes	____/____/____ <small>day month year</small>
				____/____/____ <small>day month year</small>	<input type="checkbox"/> No <input type="checkbox"/> Yes	____/____/____ <small>day month year</small>
				____/____/____ <small>day month year</small>	<input type="checkbox"/> No <input type="checkbox"/> Yes	____/____/____ <small>day month year</small>

Relevant Lab Tests:

Test	Date	Value/Results	Normal Range
	____/____/____ <small>day month year</small>		
	____/____/____ <small>day month year</small>		
	____/____/____ <small>day month year</small>		
	____/____/____ <small>day month year</small>		

Notify DCRI Safety Surveillance of the SAE within 24 hours after your knowledge

Fax SAE form to DCRI Safety Surveillance at (919) 668-7138 or 1-866-668-7138 within 24 hours of initial notification

Serious Adverse Event Form

Report type: Initial

Follow-up #: _____ Center Number: ____ Participant Number: _____ Participant's Initials: first middle last _____

Please provide a brief summary of the event:

Please describe the sequence of events including action taken, treatment given, hospital dates, etc.:

Information Source:

Date Investigator notified of Event: ____/____/____
day month year

Date of this report: ____/____/____
day month year

Person completing form: _____

Phone number: (____) _____ - _____

PI name: _____

Fax number: (____) _____ - _____

PI signature: _____

Date of signature: ____/____/____
day month year

Notify DCRI Safety Surveillance of the SAE within 24 hours after your knowledge

**Fax SAE form to DCRI Safety Surveillance at (919) 668-7138 or 1-866-668-7138
within 24 hours of initial notification**

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Excessive Weight Loss Episode

Excessive weight loss is defined as a BMI < 18.5 kg/m². This report is completed for each episode of excessive weight loss. Reporting starts when the BMI level is first observed to be < 18.5 kg/m², and ends when the episode either resolves or the participant is permanently discontinued from the CR intervention as a direct result of this episode.

A Identifying information

1 Date of initial report: ____/____/____
day month year

2 Name of person making this report: _____

B BMI below 18.5 kg/m²

3 Date of threshold value: ____/____/____
day month year

4 Height: ____ . ____ cm (from original measurement at Screening)

5 Weight: ____ . ____ kg

6 Calculated BMI: _____ kg/m²

C Temporary Discontinuation

If BMI < 18.5 kg/m², the participant is advised about the risks of excessive weight loss and is prescribed a diet plan with increased number of calories up to the baseline level for up to one month.

7 Was CR temporarily discontinued and a diet plan prescribed?

No → If No: Indicate the reason why it was not temporarily discontinued: _____

Yes → If Yes: Complete the Temporary Discontinuation from CR Intervention form and fax to Safety Surveillance immediately. Continue to section D below.

D Follow-up BMI Value

The CR intervention is only restarted if the BMI increases to 18.5 kg/m² or higher after one month of treatment.

8 Date of follow-up value: ____/____/____
day month year

9 Weight: ____ . ____ kg

10 Calculated BMI: _____ kg/m²

E Permanent Discontinuation

If BMI is still < 18.5 kg/m² after one month of increased calorie intake, CR intervention is permanently discontinued.

11 Was the participant permanently discontinued from the CR intervention?

No → If No: Indicate the reason CR was not permanently discontinued (check only one):

BMI returned to 18.5 kg/m² or higher

Other (specify): _____

Yes → If Yes: Complete the Permanent Discontinuation from CR Intervention form and fax to Safety Surveillance immediately.

Note that a participant is permanently discontinued from the CR intervention if a BMI < 18.5 kg/m² occurs at any point after the CR was restarted. If this happens, complete the Permanent Discontinuation from CR Intervention form.

Fax to Safety Surveillance at 1-866-668-7138

Excessive Weight Loss Episode Report

Center Number: ____ Participant Number: ____ Participant's Initials: first middle last ____

Excessive Weight Loss Episode (continued)

F Please provide a description of this episode including actions taken:

Study Manager's Signature

Signature: _____ Date: ____/____/____
day month year

Center Number: ____ Participant Number: ____ Participant's Initials: first middle last ____

Depression Episode

Depression is defined as a BDI score ≥ 20 . This report is completed for each episode of depression. Reporting starts when the initial BDI is ≥ 20 , and ends when the episode either resolves or the participant is permanently discontinued from the CR intervention.

A Identifying information

1 Date of initial report: ____/____/____
day month year

2 Name of person making this report: _____

B Initial Elevation in BDI Score ≥ 20

3 Date of initial elevation: ____/____/____
day month year

4 BDI score: _____

C Repeat BDI Score

The questionnaire is repeated in **one week**.

5 Date of follow-up questionnaire: ____/____/____
day month year

6 BDI score: _____

D Temporary Discontinuation

If the repeat score is ≥ 20 , the CR intervention is temporarily discontinued and a participant is advised to seek medical help outside of the study.

7 Was the participant temporarily discontinued from the CR intervention?

No → If No: Indicate the reason CR was not temporarily discontinued (check only one):

BDI score returned to < 20 → If the BDI score returned to < 20 , then stop here; the episode has resolved.

Sign the form on the last page and store in participant's binder.

Other (specify): _____

Yes → If Yes: Complete the Temporary Discontinuation from CR Intervention form and fax to Safety Surveillance immediately.

E Follow-up BDI Score

The questionnaire is repeated in **one month**.

8 Date of follow-up questionnaire: ____/____/____
day month year

9 BDI score: _____

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Eating Disorder Episode

Eating disorders are defined in terms of scores on the Multi-axial Assessment of Eating Disorder Symptoms (MAEDS) and the Body Acceptability Morph (BAM) and Interview for the Diagnosis of Eating Disorders—Fourth Version (IDED-IV). Reporting starts when MAEDS and/or BAM **indicate** that there is an eating disorder, and ends when the episode either resolves or the participant is permanently discontinued from the CR intervention.

A Identifying information

1 Date of initial report: ____/____/____
day month year

2 Name of person making this report: _____

Please complete Section B and/or C according to whether the episode was defined in terms of the MAEDS or the BAM, or both.

B Disorder Detected by the MAEDS A participant who has a t-score of 70 or higher on any subscale of the MAEDS is administered the IDED-IV.

MAEDS Domain	t-score	MAEDS Domain	t-score
3 Binge eating	_____	6 Purgative behavior	_____
4 Restrictive eating	_____	7 Avoidance of forbidden foods	_____
5 Fear of fatness	_____	8 Depression	_____

C Disorder Detected by the BAM

A participant who (a) scores a t-score of 70 or higher on the current body size, (b) scores a t-score lower than 30 on the ideal body size, or (c) shows confirming acceptability of the extreme body size shown in the acceptability phase of the measure is administered the IDED-IV.

9 Was an alert issued for the current body size scale? No Yes → If Yes: t-score: _____

10 Was an alert issued for the ideal body size scale? No Yes → If Yes: t-score: _____

11 Was there confirming acceptability of the extreme body size shown? No Yes

D Follow-up with IDED-IV

The diagnostic criteria for anorexia nervosa, bulimia nervosa, or binge eating disorder require an IDED-IV rating of "3" or more for each of its diagnostic criteria. A sub threshold eating disorder is defined as an IDED-IV rating of "3" or more on at least 5 of the 8 combined symptoms for bulimia nervosa and anorexia nervosa (only).

12 Did the participant meet the following diagnostic criteria (check all that apply)?

Anorexia nervosa No Yes

Bulimia nervosa No Yes

Binge eating No Yes

Sub threshold eating disorder No Yes

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Elevated Potassium Episode

Hyperkalemia is defined as an initial potassium level greater than 5.5 mEq/L followed by a confirmatory value greater than 5.5 mEq/L. This report is completed for each episode of hyperkalemia. Reporting starts when the initial potassium level is greater than 5.5 mEq/L, and ends when the episode either resolves or the participant is permanently discontinued from the CR intervention as a direct result of this episode.

A Identifying information

1 Date of initial report: ____/____/____
day month year

2 Name of person making this report: _____

B Initial Elevation in Potassium Level

3 Date of initial elevation: ____/____/____
day month year

4 Potassium level: _____ mEq/L

C Follow-up Repeat Potassium Level

If the initial potassium level is between 5.5 mEq/L and 6.0 mEq/L (inclusive), the test is repeated in one week; if it is greater than 6.0 mEq/L, it is repeated within 48 hours.

5 Date of follow-up test: ____/____/____
day month year

6 Potassium level: _____ mEq/L

D Temporary Discontinuation

If the follow-up test is > 5.5 mEq/L, the CR intervention is temporarily discontinued from the CR intervention and the participant is advised to seek medical help outside of the study.

7 Was the participant temporarily discontinued from the CR intervention?

₀ No → If No: Indicate the reason CR was not temporarily discontinued (check only one):

₁ Potassium returned to 5.5 mEq/L or lower → If potassium returned to 5.5 mEq/L or lower, then the episode has resolved. Stop here, sign the form on the last page, and store in the participant's binder.

₉₈ Other (specify): _____

₁ Yes → If Yes: Complete the Temporary Discontinuation from CR Intervention form and fax to Safety Surveillance immediately. Continue to Section E below.

E Follow-up Potassium Level

The CR intervention will only be restarted if the potassium level decreases to ≤ 5.0 mEq/L within one month of treatment.

8 Date of follow-up test: ____/____/____
day month year

9 Potassium level: _____ mEq/L

Center Number: ____ Participant Number: ____ Participant's Initials: ____
first middle last

Elevated Potassium Episode (continued)

F Permanent Discontinuation

If potassium level is still elevated above 5.0 mEq/L after one month of treatment, the CR intervention is permanently discontinued.

10 Was the participant permanently discontinued from the CR intervention?

- No → If No: Indicate why CR was not permanently discontinued (check only one):
- Potassium returned to 5.0 mEq/L or lower
 - Other (specify): _____
- Yes → If Yes: Complete the Permanent Discontinuation from CR Intervention form and fax to Safety Surveillance immediately.

Note that a participant is permanently discontinued from the CR intervention if a potassium level of 5.5 mEq/L or higher occurs at any point after the CR was restarted. If this happens, complete the Permanent Discontinuation from CR Intervention form.

G Please provide a description of this episode including actions taken:

Study Manager's Signature:

Signature: _____ Date: ____/____/____
day month year

Center Number: ____ Participant Number: ____ Participant's Initials: first middle last ____

Anemia Episode

Anemia is defined as a decrease in hemoglobin and/or hematocrit level below the lower limit of normal (LLN) for the laboratory, followed by a confirmatory value satisfying the same criteria. Reporting starts when the **initial** value is observed, and ends when the episode either resolves or the participant is permanently discontinued from the CR intervention.

A Identifying Information

1 Date of initial report: ____/____/____
day month year

2 Name of person making this report: _____

Please complete Section B according to whether the hemoglobin and/or hematocrit was below the lower limit of normal.

B Value(s) Below the Lower Limit of Normal:

3 Date of lab test: ____/____/____
day month year

	Value	Lower Limit of Normal (LLN)	Below LLN?
4 Hemoglobin:			<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
5 Hematocrit:			<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
6 RBC:			<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
7 Iron level:			<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes

C

D Repeat Test:

The hematology panel is repeated in two weeks. The iron level is also repeated.

11 Date of repeat lab test: ____/____/____
day month year

	Value	Lower Limit of Normal (LLN)	Below LLN?
12 Hemoglobin:			<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
13 Hematocrit:			<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
14 RBC:			<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
15 Iron level:			<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes

If the repeated test confirms the previous findings, a participant is advised to seek medical help outside of the study. Nevertheless, s/he continues the CR intervention.

Center Number: ____ Participant Number: ____ Participant's Initials:
first middle last

Anemia Episode (continued)

E Medical Help Outside the Study:

16 Was the participant advised to seek medical help outside the study?

No → If No: Indicate the reason why not:

Hematology panel and iron levels returned to acceptable values → If the hematology and iron levels return to acceptable values, then the episode has resolved. Stop here, sign the form on the last page, and store in the participant's binder.

Other (specify): _____

Yes → If Yes: Date on which patient was advised: ____/____/____
day month year

F One Month Follow-up Test

If the hematology and iron levels do **not** return to acceptable values, the hematology panel and iron levels are repeated one month after the treatment was initiated.

17 Date of one month follow-up lab test: ____/____/____
day month year

	Value	Lower Limit of Normal (LLN)	Below LLN?
18 Hemoglobin:			<input type="checkbox"/> No <input type="checkbox"/> Yes
19 Hematocrit:			<input type="checkbox"/> No <input type="checkbox"/> Yes
20 RBC:			<input type="checkbox"/> No <input type="checkbox"/> Yes
21 Iron level:			<input type="checkbox"/> No <input type="checkbox"/> Yes

G Temporary Discontinuation

If anemia is not improving or worsens, the CR intervention is temporarily discontinued.

22 Was the participant temporarily discontinued from the CR intervention?

No → If No: Indicate the reason why CR was not temporarily discontinued (check only one):

Hemoglobin panel and iron levels returned to acceptable values → If the hemoglobin and iron levels return to acceptable levels, the episode has resolved. Stop here, sign the form on the last page, and forward to the coordinating center with the next batch of data forms.

Other (specify): _____

Yes → If Yes: Complete the Temporary Discontinuation from CR Intervention form and fax to Safety Surveillance immediately.

Continue to Section H, next page.

Center Number: ____ Participant Number: ____ Participant's Initials: ____
first middle last

Anemia Episode (continued)

H Two Month Follow-up Value

If anemia is not improving or is worsening after the CR intervention was temporarily discontinued for one month, the intervention is permanently discontinued.

23 Date of two month follow-up lab test: ____/____/____
day month year

	Value	Lower Limit of Normal (LLN)	Below LLN?
24 Hemoglobin:			<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
25 Hematocrit:			<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
26 RBC:			<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
27 Iron level:			<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes

I Permanent Discontinuation

28 Was the participant permanently discontinued from the CR intervention?

₀ No → If No: Indicate the reason why CR was not permanently discontinued (check only one):

₁ Hemoglobin panel and iron levels returned to acceptable values

₉₈ Other (specify): _____

₁ Yes → If Yes: Please complete the Permanent Discontinuation from CR Intervention form and fax to Safety Surveillance immediately.

J Please provide a description of this episode including actions taken: _____

Study Manager's Signature:

Signature: _____ Date: ____/____/____
day month year

Center Number: ____ Participant Number: ____ Participant's Initials: first middle last ____

Ventricular Ischemia Episode

This report is completed if an episode of ventricular ischemia occurs during the VO₂ max measurement (12 or 24 months). Reporting starts when it is first observed, and ends when the episode either resolves or the participant is permanently discontinued from the CR intervention.

A Identifying information

1 Date of initial report: ____/____/____
day month year

2 Name of person making this report: _____

B Date when the ventricular ischemia was observed

3 Date: ____/____/____
day month year

C Temporary Discontinuation

The CR intervention is temporarily discontinued and a stress imaging study is recommended within two weeks.

4 Was CR temporarily discontinued and a stress imaging study ordered?

No → If No: Indicate the reason CR was not temporarily discontinued: _____

Yes → If Yes: Complete the Temporary Discontinuation from CR Intervention form and fax to Safety Surveillance immediately. Continue to Section D below.

D Stress Imaging Study

If a stress imaging study confirms presence of ventricular ischemia, the CR intervention will be permanently discontinued and a participant will follow all other study procedures to the study end.

5 Date of study: ____/____/____
day month year

6 Did the study confirm the presence of ventricular ischemia?

No

Yes

E Permanent Discontinuation

7 Was the participant permanently discontinued from the CR intervention?

No → If No: Indicate the reason CR was not permanently discontinued:

The study did not confirm the presence of ventricular ischemia.

Other (specify): _____

Yes → If Yes: Complete the Permanent Discontinuation from CR Intervention form and fax to Safety Surveillance immediately.

Check one: Initial Follow-up

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Temporary Discontinuation

Note: Complete ONE form per reason for discontinuation.

1 Date of temporary discontinuation: ____/____/____
day month year

2 Reason for discontinuation (check only one):

- ₁ Persistent potassium level > 5.5 mEq/L and < 6.0 mEq/L at any point during study, confirmed by repeat testing at 1 week
- ₂ Persistent potassium level ≥ 6.1 mEq/L at any point during study, confirmed by repeat testing at 48 hours if second level is above 5.5 mEq/L
- ₃ Treatment resistant anemia (*anemia has not improved after one month of treatment*)
- ₄ Ventricular ischemia observed with exercise (*stress image performed in 2 weeks*)
- ₅ Decrease in BMI to < 18.5 at any time
- ₆ Moderate depression (*BDI ≥ 20*)
- ₇ Personal reasons (*specify*): _____
- ₈ Other (*includes any other disease or condition that requires temporary discontinuation from intervention such as recovery from trauma, surgery, or severe infections*) (*specify*): _____

Participant's Details:

Date of birth: ____/____/____
day month year

Height: _____ . ____ cm

Gender: Male Female

Weight: _____ . ____ kg

BMI (if applicable): _____

Relevant Medical History:

Relevant Concomitant Medication (do not list medication administered to treat this event):

Medication	Dose & Unit	Frequency	Route	Start Date	Continued	Stop Date
				____/____/____ <small>day month year</small>	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	____/____/____ <small>day month year</small>
				____/____/____ <small>day month year</small>	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	____/____/____ <small>day month year</small>
				____/____/____ <small>day month year</small>	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	____/____/____ <small>day month year</small>

Relevant Lab Tests:

Test	Date	Value/Results	Normal Range
	____/____/____ <small>day month year</small>		
	____/____/____ <small>day month year</small>		
	____/____/____ <small>day month year</small>		
	____/____/____ <small>day month year</small>		

Fax to Safety Surveillance at 1-866-668-7138

Center Number: ____ Participant Number: ____ Participant's Initials: first middle last ____

Temporary Discontinuation (continued)

Please describe any additional action taken (e.g., observation or seek medical attention outside study):

Intervention Resumption

Was intervention resumed? If No: Fill out Permanent Discontinuation from CR Intervention form

If Yes: Date intervention was resumed: ____/____/____
day month year

Investigator's Signature

Investigator: _____ Date: ____/____/____
signature day month year

Center Number: ____ Participant Number: ____ Participant's Initials: first middle last ____

Permanent Discontinuation

1 Date of permanent discontinuation: ____/____/____
day month year

2 Reason(s) for discontinuation (check only one):

- ₁ Persistent potassium level > 5.0 mEq/L resistant to one month of treatment
- ₂ Persistent potassium level ≥ 5.5 mEq/L after CR was temporarily discontinued and restarted
- ₃ Persistent anemia (*anemia still not improving or worsening one month after temporary discontinuation*)
- ₄ Ventricular ischemia confirmed by stress image
- ₅ Decrease in BMD at the hip or spine of 5% or greater from baseline at any time during first 12 months of CR
- ₆ Decrease in BMD at the hip or spine of 10% or greater from baseline at any time during months 12–24 of CR
- ₇ BMD t-score at any site (*hip, femoral neck, or total spine*) of less than -2.5 at any time during study
- ₈ Eating disorder (*including anorexia nervosa, bulimia nervosa or binge eating OR experiencing a sub-threshold eating disorder*)
- ₉ Further decrease in BMI after 1 month of increase calorie intake **OR** temporary discontinuation of CR intervention **OR** persistent decrease in BMI (< 18.5) after CR intervention restarted
- ₁₀ Psychiatric disorder (*including severe depression*)
- ₁₁ Reoccurrence of moderate depression (*BDI still > 20*) after CR intervention restarted **OR** moderate depression that is not improving or is worsening (*BDI ≥ 30*) after temporary discontinuation of CR intervention
- ₁₂ Major illness or disease (e.g., *cancer*)
- ₁₃ Trauma requiring prolonged hospitalization or bed rest for more than one month
- ₁₄ Menstrual irregularities or acyclicity for more than one year (*women only*)
- ₁₅ Pregnancy (*women only*)
- ₁₆ Participant withdrew consent
- ₁₇ Personal reasons (*specify*): _____
- ₉₈ Other: _____

Participant's Details:

Date of birth: ____/____/____
day month year

Height: ____ . ____ cm

Gender: Male Female

Weight: ____ . ____ kg

BMI (if applicable): _____

Relevant Medical History:

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Permanent Discontinuation (continued)

Relevant Concomitant Medication (do not list medication administered to treat this event):

Medication	Dose & Unit	Frequency	Route	Start Date	Continued	Stop Date
				____/____/____ <small>day month year</small>	<input type="checkbox"/> No <input type="checkbox"/> Yes	____/____/____ <small>day month year</small>
				____/____/____ <small>day month year</small>	<input type="checkbox"/> No <input type="checkbox"/> Yes	____/____/____ <small>day month year</small>
				____/____/____ <small>day month year</small>	<input type="checkbox"/> No <input type="checkbox"/> Yes	____/____/____ <small>day month year</small>

Relevant Lab Tests:

Test	Date	Value/Results	Normal Range
	____/____/____ <small>day month year</small>		
	____/____/____ <small>day month year</small>		
	____/____/____ <small>day month year</small>		
	____/____/____ <small>day month year</small>		

Please describe any additional action taken (e.g., observation or seek medical attention outside study):

Investigator's Signature

Investigator: _____ Date: ____/____/____
signature day month year

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Completion/Early Discontinuation

1 Date of study completion or early discontinuation of study: _____/_____/_____
day month year

2 Did the participant complete the study through Month 24?

No → If No: Date of last contact: _____/_____/_____
day month year

Indicate the primary reason for discontinuation (check only one):

Consent withdrawn

Lost to follow-up

Adverse event → Complete Signs, Symptoms and Adverse Events Log

• If serious adverse event, complete Serious Adverse Event (SAE) form

Death → Date of death: _____/_____/_____
day month year

• Complete Signs, Symptoms and Adverse Events Log

• Complete Serious Adverse Events form

• Report cause of death as a Serious Adverse Event

Other (specify): _____

Yes

Center Number: ____ Participant Number: ____ Participant's Initials: ____
first middle last

Protocol Deviation

Please indicate below any deviations from the Calerie Protocol taken for this participant.

Check all that apply (one participant per form):

Baseline 1 Baseline 2 Month 1 Month 3 Month 6 Month 9 Month 12 Month 18 Month 24

Date of deviation: ____/____/____
day month year

- | | |
|---|---|
| <input type="checkbox"/> Informed Consent | <input type="checkbox"/> Study/laboratory procedures (specify): _____ |
| <input type="checkbox"/> Inclusion/Exclusion criteria | <input type="checkbox"/> Participant non-fasting |
| <input type="checkbox"/> Randomization/treatment assignment | <input type="checkbox"/> Participant safety (specify): _____ |
| <input type="checkbox"/> Concomitant Medications | <input type="checkbox"/> Other (specify): _____ |

Brief explanation of deviation: _____

Baseline 1 Baseline 2 Month 1 Month 3 Month 6 Month 9 Month 12 Month 18 Month 24

Date of deviation: ____/____/____
day month year

- | | |
|---|---|
| <input type="checkbox"/> Informed Consent | <input type="checkbox"/> Study/laboratory procedures (specify): _____ |
| <input type="checkbox"/> Inclusion/Exclusion criteria | <input type="checkbox"/> Participant non-fasting |
| <input type="checkbox"/> Randomization/treatment assignment | <input type="checkbox"/> Participant safety (specify): _____ |
| <input type="checkbox"/> Concomitant Medications | <input type="checkbox"/> Other (specify): _____ |

Brief explanation of deviation: _____

Baseline 1 Baseline 2 Month 1 Month 3 Month 6 Month 9 Month 12 Month 18 Month 24

Date of deviation: ____/____/____
day month year

- | | |
|---|---|
| <input type="checkbox"/> Informed Consent | <input type="checkbox"/> Study/laboratory procedures (specify): _____ |
| <input type="checkbox"/> Inclusion/Exclusion criteria | <input type="checkbox"/> Participant non-fasting |
| <input type="checkbox"/> Randomization/treatment assignment | <input type="checkbox"/> Participant safety (specify): _____ |
| <input type="checkbox"/> Concomitant Medications | <input type="checkbox"/> Other (specify): _____ |

Brief explanation of deviation: _____

Submission date: ____/____/____ ____/____/____ ____/____/____
day month year day month year day month year