

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): ☐<sub>1</sub> Left arm ☐<sub>2</sub> 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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## 12-Lead ECG

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

## 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"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Yes	_____	_____ first middle last
Urine	<input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Yes	_____	_____ first middle last

## Pregnancy Test

**Complete only for females.**

Does participant have reproductive potential?

☐ <sub>0</sub> No

☐ <sub>1</sub> Yes → If Yes: Date urine pregnancy test performed: \_\_\_\_/\_\_\_\_/\_\_\_\_  
day month year

Results: ☐ <sub>1</sub> Negative

☐ <sub>2</sub> Positive

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### 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

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

### Physician's Signature

Investigator: \_\_\_\_\_  
signature

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
day month year

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

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### DXA Scan

**1** Has the participant taken a calcium supplement today?

☐<sub>0</sub> No    ☐<sub>1</sub> 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?

☐<sub>0</sub> No    ☐<sub>1</sub> Yes

DXA Scan		DXA Rescan OR <input type="checkbox"/> <sub>96</sub> 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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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:** ☐<sub>1</sub> Excellent ☐<sub>2</sub> Very good ☐<sub>3</sub> Good ☐<sub>4</sub> Fair ☐<sub>5</sub> Poor

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

**4 Moderate activities**, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf ☐<sub>1</sub> ☐<sub>2</sub> ☐<sub>3</sub>

**5 Lifting or carrying groceries** ☐<sub>1</sub> ☐<sub>2</sub> ☐<sub>3</sub>

**6 Climbing several flights of stairs** ☐<sub>1</sub> ☐<sub>2</sub> ☐<sub>3</sub>

**7 Climbing one flight of stairs** ☐<sub>1</sub> ☐<sub>2</sub> ☐<sub>3</sub>

**8 Bending, kneeling or stooping** ☐<sub>1</sub> ☐<sub>2</sub> ☐<sub>3</sub>

**9 Walking more than a mile** ☐<sub>1</sub> ☐<sub>2</sub> ☐<sub>3</sub>

**10 Walking several blocks** ☐<sub>1</sub> ☐<sub>2</sub> ☐<sub>3</sub>

**11 Walking one block** ☐<sub>1</sub> ☐<sub>2</sub> ☐<sub>3</sub>

**12 Bathing or dressing yourself** ☐<sub>1</sub> ☐<sub>2</sub> ☐<sub>3</sub>

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### 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

☐ <sub>1</sub>
☐ <sub>2</sub>

**14** Accomplished less than you would like

☐ <sub>1</sub>
☐ <sub>2</sub>

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

☐ <sub>1</sub>
☐ <sub>2</sub>

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

☐ <sub>1</sub>
☐ <sub>2</sub>

**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

☐ <sub>1</sub>
☐ <sub>2</sub>

**18** Accomplished less than you would like

☐ <sub>1</sub>
☐ <sub>2</sub>

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

☐ <sub>1</sub>
☐ <sub>2</sub>

**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?

- ☐ <sub>1</sub> Not at all
- ☐ <sub>2</sub> Slightly
- ☐ <sub>3</sub> Moderately
- ☐ <sub>4</sub> Quite a bit
- ☐ <sub>5</sub> Extremely

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

- ☐ <sub>1</sub> None
- ☐ <sub>2</sub> Very mild
- ☐ <sub>3</sub> Mild
- ☐ <sub>4</sub> Moderate
- ☐ <sub>5</sub> Severe
- ☐ <sub>6</sub> 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)?

- ☐ <sub>1</sub> Not at all
- ☐ <sub>2</sub> A little bit
- ☐ <sub>3</sub> Moderately
- ☐ <sub>4</sub> Quite a bit
- ☐ <sub>5</sub> 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
<b>23</b> 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
<b>24</b> 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
<b>25</b> 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
<b>26</b> 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
<b>27</b> 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
<b>28</b> 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
<b>29</b> 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
<b>30</b> 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
<b>31</b> 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
<b>32</b> 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	
	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4	<input type="checkbox"/> _5	
<b>How true or false is each of the following statements for you?</b>	<b>Definitely True</b>	<b>Mostly True</b>	<b>Don't Know</b>	<b>Mostly False</b>	<b>Definitely False</b>	
<b>33</b> 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	
<b>34</b> 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	
<b>35</b> 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	
<b>36</b> My health is excellent.	<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: \_\_\_\_/\_\_\_\_/\_\_\_\_ 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:**
  - ☐<sub>0</sub> I do not feel sad
  - ☐<sub>1</sub> I feel sad much of the time
  - ☐<sub>2</sub> I am sad all of the time
  - ☐<sub>3</sub> I am so sad or unhappy that I can't stand it
- 2 Pessimism:**
  - ☐<sub>0</sub> I am not discouraged about my future
  - ☐<sub>1</sub> I feel more discouraged about my future than I used to be
  - ☐<sub>2</sub> I do not expect things to work out for me
  - ☐<sub>3</sub> I feel my future is hopeless and will only get worse
- 3 Past failure:**
  - ☐<sub>0</sub> I do not feel like a failure
  - ☐<sub>1</sub> I have failed more than I should have
  - ☐<sub>2</sub> As I look back, I see a lot of failures
  - ☐<sub>3</sub> I feel I am a total failure as a person
- 4 Loss of pleasure:**
  - ☐<sub>0</sub> I get as much pleasure as I ever did from the things I enjoy
  - ☐<sub>1</sub> I don't enjoy things as much as I used to
  - ☐<sub>2</sub> I get very little pleasure from the things I used to enjoy
  - ☐<sub>3</sub> I can't get any pleasure from the things I used to enjoy
- 5 Guilty feelings:**
  - ☐<sub>0</sub> I don't feel particularly guilty
  - ☐<sub>1</sub> I feel guilty over many things I have done or should have done
  - ☐<sub>2</sub> I feel quite guilty most of the time
  - ☐<sub>3</sub> I feel guilty all of the time
- 6 Punishment feelings:**
  - ☐<sub>0</sub> I don't feel I am being punished
  - ☐<sub>1</sub> I feel I may be punished
  - ☐<sub>2</sub> I expect to be punished
  - ☐<sub>3</sub> I feel I am being punished
- 7 Self-dislike:**
  - ☐<sub>0</sub> I feel the same about myself as ever
  - ☐<sub>1</sub> I have lost confidence in myself
  - ☐<sub>2</sub> I am disappointed in myself
  - ☐<sub>3</sub> I dislike myself

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### BDI-II (continued)

#### 8 Self-criticalness:

- ☐<sub>0</sub> I don't criticize or blame myself more than usual
- ☐<sub>1</sub> I am more critical of myself than I used to be
- ☐<sub>2</sub> I criticize myself for all of my faults
- ☐<sub>3</sub> I blame myself for everything bad that happens

#### 9 Suicidal thoughts or wishes:

- ☐<sub>0</sub> I don't have any thoughts of killing myself
- ☐<sub>1</sub> I have thoughts of killing myself but I would not carry them out
- ☐<sub>2</sub> I would like to kill myself
- ☐<sub>3</sub> I would kill myself if I had the chance

#### 10 Crying:

- ☐<sub>0</sub> I don't cry any more than I used to
- ☐<sub>1</sub> I cry more than I used to
- ☐<sub>2</sub> I cry over every little thing
- ☐<sub>3</sub> I feel like crying, but I can't

#### 11 Agitation:

- ☐<sub>0</sub> I am no more wound up or restless than usual
- ☐<sub>1</sub> I feel more restless or wound up than usual
- ☐<sub>2</sub> I am so restless or agitated that it's hard to stay still
- ☐<sub>3</sub> I am so restless or agitated that I have to keep moving or doing something

#### 12 Loss of interest:

- ☐<sub>0</sub> I have not lost interest in other people or activities
- ☐<sub>1</sub> I am less interested in other people or things than before
- ☐<sub>2</sub> I have lost most of my interest in other people or things
- ☐<sub>3</sub> It's hard to get interested in anything

#### 13 Indecisiveness:

- ☐<sub>0</sub> I make decisions about as well as ever
- ☐<sub>1</sub> I find it more difficult to make decisions than usual
- ☐<sub>2</sub> I have much greater difficulty in making decisions than I used to
- ☐<sub>3</sub> I have trouble making my decisions

#### 14 Worthlessness:

- ☐<sub>0</sub> I do not feel I am worthless
- ☐<sub>1</sub> I don't consider myself as worthwhile and useful as I used to
- ☐<sub>2</sub> I feel more worthless as compared to other people
- ☐<sub>3</sub> I feel utterly worthless

#### 15 Loss of energy:

- ☐<sub>0</sub> I have as much energy as ever
- ☐<sub>1</sub> I have less energy than I used to have
- ☐<sub>2</sub> I don't have enough energy to do very much
- ☐<sub>3</sub> 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:** ☐<sub>0</sub> I have not experienced any change in my sleeping pattern

☐<sub>1</sub> I sleep somewhat more than usual

☐<sub>2</sub> I sleep somewhat less than usual

☐<sub>3</sub> I sleep a lot more than usual

☐<sub>4</sub> I sleep a lot less than usual

☐<sub>5</sub> I sleep most of the day

☐<sub>6</sub> I wake up 1-2 hours early and can't get back to sleep

**17 Irritability:**

☐<sub>0</sub> I am no more irritable than usual

☐<sub>1</sub> I am more irritable than usual

☐<sub>2</sub> I am much more irritable than usual

☐<sub>3</sub> I am irritable all of the time

**18 Changes in appetite:**

☐<sub>0</sub> I have not experienced any change in my appetite

☐<sub>1</sub> My appetite is somewhat less than usual

☐<sub>2</sub> My appetite is somewhat greater than usual

☐<sub>3</sub> My appetite is much less than before

☐<sub>4</sub> My appetite is much greater than usual

☐<sub>5</sub> I have no appetite at all

☐<sub>6</sub> I crave food all of the time

**19 Concentration difficulty:**

☐<sub>0</sub> I can concentrate as well as ever

☐<sub>1</sub> I can't concentrate as well as usual

☐<sub>2</sub> It's hard to keep my mind on anything for very long

☐<sub>3</sub> I find I can't concentrate on anything

**20 Tiredness or fatigue:**

☐<sub>0</sub> I am no more tired or fatigued than usual

☐<sub>1</sub> I get more tired or fatigued more easily than usual

☐<sub>2</sub> I am too tired or fatigued to do a lot of the things I used to do

☐<sub>3</sub> I am too tired or fatigued to do most of the things I used to do

**21 Loss of interest in sex:**

☐<sub>0</sub> I have not noticed any recent change in my interest in sex

☐<sub>1</sub> I am less interested in sex than I used to be

☐<sub>2</sub> I am much less interested in sex now

☐<sub>3</sub> 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

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### Profile of Mood States (continued)

Feeling	Not At All	A Little	Moderately	Quite A Bit	Extremely
<b>21 Hopeless</b>	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
<b>22 Relaxed</b>	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
<b>23 Unworthy</b>	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
<b>24 Spiteful</b>	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
<b>25 Sympathetic</b>	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
<b>26 Uneasy</b>	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
<b>27 Restless</b>	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
<b>28 Unable to concentrate</b>	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
<b>29 Fatigued</b>	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
<b>30 Helpful</b>	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
<b>31 Annoyed</b>	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
<b>32 Discouraged</b>	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
<b>33 Resentful</b>	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
<b>34 Nervous</b>	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
<b>35 Lonely</b>	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
<b>36 Miserable</b>	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
<b>37 Muddled</b>	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
<b>38 Cheerful</b>	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
<b>39 Bitter</b>	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
<b>40 Exhausted</b>	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
<b>41 Anxious</b>	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
<b>42 Ready to fight</b>	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
<b>43 Good-natured</b>	<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 Number: \_\_\_\_

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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"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
45 Desperate	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
46 Sluggish	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
47 Rebellious	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
48 Helpless	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
49 Weary	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
50 Bewildered	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
51 Alert	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
52 Deceived	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
53 Furious	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
54 Efficient	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
55 Trusting	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
56 Full of pep	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
57 Bad-tempered	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
58 Worthless	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
59 Forgetful	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
60 Carefree	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
61 Terrified	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
62 Guilty	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
63 Vigorous	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
64 Uncertain about things	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
65 Bushed	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>

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first middle last

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
<b>1</b> 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
<b>2</b> 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
<b>3</b> 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
<b>4</b> 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

☐<sub>0</sub> ☐<sub>1</sub> ☐<sub>2</sub> ☐<sub>3</sub>

**b** Wake up in the middle of the night or early morning

☐<sub>0</sub> ☐<sub>1</sub> ☐<sub>2</sub> ☐<sub>3</sub>

**c** Have to get up to use the bathroom

☐<sub>0</sub> ☐<sub>1</sub> ☐<sub>2</sub> ☐<sub>3</sub>

**d** Cannot breathe comfortably

☐<sub>0</sub> ☐<sub>1</sub> ☐<sub>2</sub> ☐<sub>3</sub>

**e** Cough or snore loudly

☐<sub>0</sub> ☐<sub>1</sub> ☐<sub>2</sub> ☐<sub>3</sub>

**f** Feel too cold

☐<sub>0</sub> ☐<sub>1</sub> ☐<sub>2</sub> ☐<sub>3</sub>

**g** Feel too hot

☐<sub>0</sub> ☐<sub>1</sub> ☐<sub>2</sub> ☐<sub>3</sub>

**h** Have bad dreams

☐<sub>0</sub> ☐<sub>1</sub> ☐<sub>2</sub> ☐<sub>3</sub>

**i** Have pain

☐<sub>0</sub> ☐<sub>1</sub> ☐<sub>2</sub> ☐<sub>3</sub>

**j** Other reason(s), please describe, including how often you have had trouble sleeping because of this reason(s): \_\_\_\_\_

☐<sub>0</sub> ☐<sub>1</sub> ☐<sub>2</sub> ☐<sub>3</sub>

**6** During the past month, how often have you taken medicine (prescribed or "over the counter") to help you sleep?

☐<sub>0</sub> ☐<sub>1</sub> ☐<sub>2</sub> ☐<sub>3</sub>

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Participant's Initials: \_\_\_\_\_  
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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?

☐<sub>0</sub>

☐<sub>1</sub>

☐<sub>2</sub>

☐<sub>3</sub>

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?

☐<sub>0</sub>

☐<sub>1</sub>

☐<sub>2</sub>

☐<sub>3</sub>

Very good      Fairly good      Fairly bad      Very bad

9 During the past month, how would you rate your sleep quality overall?

☐<sub>0</sub>

☐<sub>1</sub>

☐<sub>2</sub>

☐<sub>3</sub>

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): \_\_\_\_

### 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
<b>1.1</b> 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
<b>1.2</b> 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
<b>1.3</b> 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
<b>1.4</b> 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
<b>1.5</b> 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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**Not Done Codelist:** 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

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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
<b>2.1</b> 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
<b>2.2</b> 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
<b>2.3</b> 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				
<b>2.4</b> 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				
<b>2.5</b> 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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first middle last

## 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
<b>3.1</b> 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
<b>3.2</b> 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
<b>3.3</b> 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
<b>3.4</b> 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
<b>3.5</b> 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
<b>4.1</b> 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
<b>4.2</b> 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
<b>4.3</b> 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
<b>4.4</b> 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
<b>4.5</b> 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
<b>4.6</b> 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
<b>5.1</b> With the partner of your choice, what would be your <b>ideal</b> 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				
<b>5.2</b> 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				
<b>5.3</b> 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
<b>5.4</b> 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: \_\_\_\_\_  
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Center Number: \_\_\_\_\_ Participant Number: \_\_\_\_\_ Participant's Initials: \_\_\_\_\_  
first middle last

Date completed: \_\_\_\_/\_\_\_\_/\_\_\_\_ OR Not done → Specify reason (use codelist below): \_\_\_\_\_

## 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
<b>1.1</b> 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
<b>1.2</b> 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
<b>1.3</b> 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
<b>1.4</b> 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
<b>1.5</b> 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
<b>2.1</b> 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
<b>2.2</b> 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
<b>2.3</b> 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
<b>2.4</b> 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
<b>2.5</b> 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
<b>3.1</b> 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
<b>3.2</b> 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
<b>3.3</b> 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
<b>3.4</b> 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
<b>3.5</b> 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
<b>4.1</b> 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
<b>4.2</b> 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
<b>4.3</b> 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
<b>4.4</b> 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
<b>4.5</b> 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
<b>4.6</b> 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: \_\_\_\_

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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
<b>5.1</b> 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				
<b>5.2</b> 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				
<b>5.3</b> 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
<b>5.4</b> 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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Center Number: \_\_\_\_ Participant Number: \_\_\_\_ Participant's Initials: first middle last \_\_\_\_

Date completed: \_\_\_\_/\_\_\_\_/\_\_\_\_ OR Not done → Specify reason (useodelist below): \_\_\_\_

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

### Food Craving Inventory (FCI-III)

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

Participant's Initials: \_\_\_\_\_  
first middle last

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Participant's Initials: first middle last

Date completed: \_\_\_\_/\_\_\_\_/\_\_\_\_ 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"/> 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 |

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

### Eating Inventory (continued)

19 Being with someone who is eating often makes me hungry to eat also. ☐<sub>1</sub> True ☐<sub>0</sub> False

20 When I feel blue, I often overeat. ☐<sub>1</sub> True ☐<sub>0</sub> False

21 I enjoy eating too much to spoil it by counting calories or watching my weight. ☐<sub>1</sub> True ☐<sub>0</sub> False

22 When I see a real delicacy, I often get so hungry that I have to eat right away. ☐<sub>1</sub> True ☐<sub>0</sub> False

23 I often stop eating when I am not really full as a conscious means of limiting the amount I eat. ☐<sub>1</sub> True ☐<sub>0</sub> False

24 I get so hungry that my stomach often seems like a bottomless pit. ☐<sub>1</sub> True ☐<sub>0</sub> False

25 My weight has hardly changed at all in the last ten years. ☐<sub>1</sub> True ☐<sub>0</sub> False

26 I am always hungry so it is hard for me to stop eating before I finish the food on my plate. ☐<sub>1</sub> True ☐<sub>0</sub> False

27 When I feel lonely, I console myself by eating. ☐<sub>1</sub> True ☐<sub>0</sub> False

28 I consciously hold back at meals in order not to gain weight. ☐<sub>1</sub> True ☐<sub>0</sub> False

29 I sometimes get very hungry late in the evening or at night. ☐<sub>1</sub> True ☐<sub>0</sub> False

30 I eat anything I want, any time I want. ☐<sub>1</sub> True ☐<sub>0</sub> False

31 Without even thinking about it, I take a long time to eat. ☐<sub>1</sub> True ☐<sub>0</sub> False

32 I count calories as a conscious means of controlling my weight. ☐<sub>1</sub> True ☐<sub>0</sub> False

33 I do not eat some foods because they make me fat. ☐<sub>1</sub> True ☐<sub>0</sub> False

34 I am always hungry enough to eat at any time. ☐<sub>1</sub> True ☐<sub>0</sub> False

35 I pay a great deal of attention to changes in my figure. ☐<sub>1</sub> True ☐<sub>0</sub> False

36 While on a diet, if I eat a food that is not allowed, I often splurge and eat other high calorie foods. ☐<sub>1</sub> True ☐<sub>0</sub> 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"/> <sub>1</sub> Rarely	<input type="checkbox"/> <sub>2</sub> Sometimes	<input type="checkbox"/> <sub>3</sub> Usually	<input type="checkbox"/> <sub>4</sub> Always
38	Would a weight fluctuation of 5 pounds affect the way you live your life?	<input type="checkbox"/> <sub>1</sub> Rarely	<input type="checkbox"/> <sub>2</sub> Sometimes	<input type="checkbox"/> <sub>3</sub> Usually	<input type="checkbox"/> <sub>4</sub> Always
39	How often do you feel hungry?	<input type="checkbox"/> <sub>1</sub> Rarely	<input type="checkbox"/> <sub>2</sub> Sometimes	<input type="checkbox"/> <sub>3</sub> Usually	<input type="checkbox"/> <sub>4</sub> Always
40	Do your feelings of guilt about overeating help you to control your food intake?	<input type="checkbox"/> <sub>1</sub> Rarely	<input type="checkbox"/> <sub>2</sub> Sometimes	<input type="checkbox"/> <sub>3</sub> Usually	<input type="checkbox"/> <sub>4</sub> 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"/> <sub>1</sub> Easy	<input type="checkbox"/> <sub>2</sub> Slightly difficult	<input type="checkbox"/> <sub>3</sub> Moderately difficult	<input type="checkbox"/> <sub>4</sub> Very difficult
42	How conscious are you of what you are eating?	<input type="checkbox"/> <sub>1</sub> Not at all	<input type="checkbox"/> <sub>2</sub> Slightly	<input type="checkbox"/> <sub>3</sub> Moderately	<input type="checkbox"/> <sub>4</sub> Extremely
43	How frequently do you avoid "stocking up" on tempting foods?	<input type="checkbox"/> <sub>1</sub> Almost never	<input type="checkbox"/> <sub>2</sub> Seldom	<input type="checkbox"/> <sub>3</sub> Usually	<input type="checkbox"/> <sub>4</sub> Almost always
44	How likely are you to shop for low calorie foods?	<input type="checkbox"/> <sub>1</sub> Unlikely	<input type="checkbox"/> <sub>2</sub> Slightly likely	<input type="checkbox"/> <sub>3</sub> Moderately likely	<input type="checkbox"/> <sub>4</sub> Very likely
45	Do you eat sensibly in front of others and splurge alone?	<input type="checkbox"/> <sub>1</sub> Never	<input type="checkbox"/> <sub>2</sub> Rarely	<input type="checkbox"/> <sub>3</sub> Often	<input type="checkbox"/> <sub>4</sub> Always
46	How likely are you to consciously eat slowly in order to cut down on how much you eat?	<input type="checkbox"/> <sub>1</sub> Unlikely	<input type="checkbox"/> <sub>2</sub> Slightly likely	<input type="checkbox"/> <sub>3</sub> Moderately likely	<input type="checkbox"/> <sub>4</sub> Very likely
47	How frequently do you skip dessert because you are no longer hungry?	<input type="checkbox"/> <sub>1</sub> Almost never	<input type="checkbox"/> <sub>2</sub> Seldom	<input type="checkbox"/> <sub>3</sub> At least once a week	<input type="checkbox"/> <sub>4</sub> Almost every day
48	How likely are you to consciously eat less than you want?	<input type="checkbox"/> <sub>1</sub> Unlikely	<input type="checkbox"/> <sub>2</sub> Slightly likely	<input type="checkbox"/> <sub>3</sub> Moderately likely	<input type="checkbox"/> <sub>4</sub> Very likely
49	Do you go on eating binges though you are not hungry?	<input type="checkbox"/> <sub>1</sub> Never	<input type="checkbox"/> <sub>2</sub> Rarely	<input type="checkbox"/> <sub>3</sub> Sometimes	<input type="checkbox"/> <sub>4</sub> 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."

- ☐<sub>1</sub> Not like me  
☐<sub>2</sub> Little like me  
☐<sub>3</sub> Pretty good description of me  
☐<sub>4</sub> 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?

- ☐<sub>0</sub> Eat whatever you want, whenever you want it  
☐<sub>1</sub> Usually eat whatever you want, whenever you want it  
☐<sub>2</sub> Often eat whatever you want, whenever you want it  
☐<sub>3</sub> Often limit food intake, but often "give in"  
☐<sub>4</sub> Usually limit food intake, rarely "give in"  
☐<sub>5</sub> Constantly limiting food intake, never "giving in"

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

## 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: \_\_\_\_\_  
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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.

☐<sub>0</sub> ☐<sub>1</sub> ☐<sub>2</sub> ☐<sub>3</sub> ☐<sub>4</sub> ☐<sub>5</sub> ☐<sub>6</sub> ☐<sub>7</sub> ☐<sub>8</sub> ☐<sub>9</sub>
**11** I can resist eating when I am angry  
(or irritable).

☐<sub>0</sub> ☐<sub>1</sub> ☐<sub>2</sub> ☐<sub>3</sub> ☐<sub>4</sub> ☐<sub>5</sub> ☐<sub>6</sub> ☐<sub>7</sub> ☐<sub>8</sub> ☐<sub>9</sub>
**12** I can resist eating even when I am at  
a party.

☐<sub>0</sub> ☐<sub>1</sub> ☐<sub>2</sub> ☐<sub>3</sub> ☐<sub>4</sub> ☐<sub>5</sub> ☐<sub>6</sub> ☐<sub>7</sub> ☐<sub>8</sub> ☐<sub>9</sub>
**13** I can resist eating even when others are  
pressuring me to eat.

☐<sub>0</sub> ☐<sub>1</sub> ☐<sub>2</sub> ☐<sub>3</sub> ☐<sub>4</sub> ☐<sub>5</sub> ☐<sub>6</sub> ☐<sub>7</sub> ☐<sub>8</sub> ☐<sub>9</sub>
**14** I can resist eating when I am in pain.

☐<sub>0</sub> ☐<sub>1</sub> ☐<sub>2</sub> ☐<sub>3</sub> ☐<sub>4</sub> ☐<sub>5</sub> ☐<sub>6</sub> ☐<sub>7</sub> ☐<sub>8</sub> ☐<sub>9</sub>
**15** I can resist eating just before going to  
bed.

☐<sub>0</sub> ☐<sub>1</sub> ☐<sub>2</sub> ☐<sub>3</sub> ☐<sub>4</sub> ☐<sub>5</sub> ☐<sub>6</sub> ☐<sub>7</sub> ☐<sub>8</sub> ☐<sub>9</sub>
**16** I can resist eating when I have  
experienced failure.

☐<sub>0</sub> ☐<sub>1</sub> ☐<sub>2</sub> ☐<sub>3</sub> ☐<sub>4</sub> ☐<sub>5</sub> ☐<sub>6</sub> ☐<sub>7</sub> ☐<sub>8</sub> ☐<sub>9</sub>
**17** I can resist eating when high-calorie foods  
are available.

☐<sub>0</sub> ☐<sub>1</sub> ☐<sub>2</sub> ☐<sub>3</sub> ☐<sub>4</sub> ☐<sub>5</sub> ☐<sub>6</sub> ☐<sub>7</sub> ☐<sub>8</sub> ☐<sub>9</sub>
**18** I can resist eating even when I think  
others will be upset if I don't eat.

☐<sub>0</sub> ☐<sub>1</sub> ☐<sub>2</sub> ☐<sub>3</sub> ☐<sub>4</sub> ☐<sub>5</sub> ☐<sub>6</sub> ☐<sub>7</sub> ☐<sub>8</sub> ☐<sub>9</sub>
**19** I can resist eating when I feel  
uncomfortable.

☐<sub>0</sub> ☐<sub>1</sub> ☐<sub>2</sub> ☐<sub>3</sub> ☐<sub>4</sub> ☐<sub>5</sub> ☐<sub>6</sub> ☐<sub>7</sub> ☐<sub>8</sub> ☐<sub>9</sub>
**20** I can resist eating when I am happy.

☐<sub>0</sub> ☐<sub>1</sub> ☐<sub>2</sub> ☐<sub>3</sub> ☐<sub>4</sub> ☐<sub>5</sub> ☐<sub>6</sub> ☐<sub>7</sub> ☐<sub>8</sub> ☐<sub>9</sub>

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	Some-times	Often	Very Often	Always
1 Fasting is a good way to lose weight.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>
2 My sleep isn't as good as it used to be.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>
3 I avoid eating for as long as I can.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>
4 Certain foods are "forbidden" for me to eat.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>
5 I can't keep certain foods in my house because I will binge on them.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>
6 I can easily make myself vomit.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>
7 I can feel that being fat is terrible.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>
8 I avoid greasy foods.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>
9 It's okay to binge and purge once in a while.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>
10 I don't eat certain foods.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>
11 I think I am a good person.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>
12 My eating is normal.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>
13 I can't seem to concentrate lately.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>
14 I try to diet by fasting.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>
15 I vomit to control my weight.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>
16 Lately nothing seems enjoyable anymore.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>
17 Laxatives help keep you slim.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>
18 I don't eat red meat.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>
19 I eat so rapidly I can't even taste my food.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>

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
<b>20</b> I do everything I can to avoid being overweight.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>
<b>21</b> When I feel bloated, I must do something to rid myself of that feeling.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>
<b>22</b> I overeat too frequently.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>
<b>23</b> It's okay to be overweight.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>
<b>24</b> Recently I have felt that I am a worthless person.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>
<b>25</b> I would be very upset if I gained 2 pounds.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>
<b>26</b> I crave sweets and carbohydrates.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>
<b>27</b> I lose control when I eat.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>
<b>28</b> Being fat would be terrible.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>
<b>29</b> I have thought seriously about suicide lately.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>
<b>30</b> I don't have any energy anymore.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>
<b>31</b> I eat small portions to control my weight.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>
<b>32</b> I eat 3 meals a day.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>
<b>33</b> Lately I have been easily irritated.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>
<b>34</b> Some foods should be totally avoided.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>
<b>35</b> I use laxatives to control my weight.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>
<b>36</b> I am terrified by the thought of being overweight.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>
<b>37</b> Purging is a good way to lose weight.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>
<b>38</b> I avoid fatty foods.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>

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

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

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	Sometimes	Often	Very Often	Always
1 Has feeling bored made you brood about your shape?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>
2 Have you been so worried about your shape that you have been feeling that you ought to diet?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>
3 Have you thought that your thighs, hips, or bottom are too large for the rest of you?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>
4 Have you been afraid that you might become fat (or fatter)?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>
5 Have you worried about your flesh not being firm enough?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>
6 Has feeling full (e.g., after eating a large meal) made you feel fat?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>
7 Have you felt so bad about your shape that you have cried?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>
8 Have you avoided running because your flesh might wobble?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>
9 Has being with thin women/men made you feel self-conscious about your shape?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>
10 Have you worried about your thighs spreading out when sitting down?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>
11 Has eating even a small amount of food made you feel fat?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>
12 Have you noticed the shape of other women/men and felt that your own shape compared unfavorably?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>
13 Has thinking about your shape interfered with your ability to concentrate (e.g., while watching TV, reading, listening to conversations)?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>
14 Has being naked, such as when taking a bath, made you feel fat?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>
15 Have you avoided wearing clothes which make you particularly aware of the shape of your body?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>
16 Have you imagined cutting off fleshy areas of your body?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>

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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### Body Shape Questionnaire (BSQ) (continued)

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

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: \_\_\_\_/\_\_\_\_/\_\_\_\_ : \_\_\_\_  
day month year 00:00 to 23:59

Staff initials: \_\_\_\_  
first middle last

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

**1** Dynamometer handle position: \_\_\_\_

**2** Dominant hand (check only one): ☐<sub>1</sub> Left ☐<sub>2</sub> Right ☐<sub>3</sub> Ambidextrous

**3** Handgrip strength:

Handgrip Strength	Zero Meter Check	Right Hand	Zero Meter Check	Left Hand
Test 1—peak force	<input type="checkbox"/> <sub>0</sub>	_____ kg	<input type="checkbox"/> <sub>0</sub>	_____ kg
Test 2—peak force	<input type="checkbox"/> <sub>0</sub>	_____ kg	<input type="checkbox"/> <sub>0</sub>	_____ kg
Test 3—peak force	<input type="checkbox"/> <sub>0</sub>	_____ kg	<input type="checkbox"/> <sub>0</sub>	_____ 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? ☐<sub>0</sub> No ☐<sub>1</sub> Yes
- 2** Recent injury or pain—left knee? ☐<sub>0</sub> No ☐<sub>1</sub> Yes
- 3** Specify machine used (PBRC only): ☐<sub>0</sub> Cybex ☐<sub>1</sub> Biolex

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

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*)?

- ☐<sub>1</sub> More  
☐<sub>2</sub> Less  
☐<sub>3</sub> 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?

- ☐<sub>0</sub> No  
☐<sub>1</sub> Yes

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

- ☐<sub>0</sub> No  
☐<sub>1</sub> Yes

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

- ☐<sub>0</sub> No  
☐<sub>1</sub> 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"/> <sub>1</sub> Reliable <input type="checkbox"/> <sub>2</sub> Unreliable <input type="checkbox"/> <sub>3</sub> Missing	8	____/____/____ <small>day month year</small>	<input type="checkbox"/> <sub>1</sub> Reliable <input type="checkbox"/> <sub>2</sub> Unreliable <input type="checkbox"/> <sub>3</sub> Missing
2	____/____/____ <small>day month year</small>	<input type="checkbox"/> <sub>1</sub> Reliable <input type="checkbox"/> <sub>2</sub> Unreliable <input type="checkbox"/> <sub>3</sub> Missing	9	____/____/____ <small>day month year</small>	<input type="checkbox"/> <sub>1</sub> Reliable <input type="checkbox"/> <sub>2</sub> Unreliable <input type="checkbox"/> <sub>3</sub> Missing
3	____/____/____ <small>day month year</small>	<input type="checkbox"/> <sub>1</sub> Reliable <input type="checkbox"/> <sub>2</sub> Unreliable <input type="checkbox"/> <sub>3</sub> Missing	10	____/____/____ <small>day month year</small>	<input type="checkbox"/> <sub>1</sub> Reliable <input type="checkbox"/> <sub>2</sub> Unreliable <input type="checkbox"/> <sub>3</sub> Missing
4	____/____/____ <small>day month year</small>	<input type="checkbox"/> <sub>1</sub> Reliable <input type="checkbox"/> <sub>2</sub> Unreliable <input type="checkbox"/> <sub>3</sub> Missing	11	____/____/____ <small>day month year</small>	<input type="checkbox"/> <sub>1</sub> Reliable <input type="checkbox"/> <sub>2</sub> Unreliable <input type="checkbox"/> <sub>3</sub> Missing
5	____/____/____ <small>day month year</small>	<input type="checkbox"/> <sub>1</sub> Reliable <input type="checkbox"/> <sub>2</sub> Unreliable <input type="checkbox"/> <sub>3</sub> Missing	12	____/____/____ <small>day month year</small>	<input type="checkbox"/> <sub>1</sub> Reliable <input type="checkbox"/> <sub>2</sub> Unreliable <input type="checkbox"/> <sub>3</sub> Missing
6	____/____/____ <small>day month year</small>	<input type="checkbox"/> <sub>1</sub> Reliable <input type="checkbox"/> <sub>2</sub> Unreliable <input type="checkbox"/> <sub>3</sub> Missing	13	____/____/____ <small>day month year</small>	<input type="checkbox"/> <sub>1</sub> Reliable <input type="checkbox"/> <sub>2</sub> Unreliable <input type="checkbox"/> <sub>3</sub> 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

## VO<sub>2</sub> Max

**1 Date and time of test:** \_\_\_\_/\_\_\_\_/\_\_\_\_ 00:00 to 23:59  
day month year

**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):** ☐<sub>1</sub> Sinus ☐<sub>2</sub> Atrial fibrillation ☐<sub>98</sub> Other  
**Ventricular conduction (check only one):** ☐<sub>1</sub> Normal ☐<sub>2</sub> LBBB ☐<sub>3</sub> 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 ☐<sub>96</sub> NA  
HR when ischemic ECG changes occurred: \_\_\_\_\_ bpm OR ☐<sub>96</sub> 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])?**

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

**7 Peak VO<sub>2</sub>:** \_\_\_\_\_ mL/kg/min \_\_\_\_\_ L/min

**8 Did the participant meet at least 2 of the 3 VO<sub>2</sub> max criteria (see box, right)?**

- ☐<sub>0</sub> No  
☐<sub>1</sub> Yes → **If Yes: VO<sub>2</sub> max:** \_\_\_\_\_ mL/kg/min \_\_\_\_\_ L/min

a Achieve a plateau in VO<sub>2</sub> (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 VO<sub>2</sub> peak/VO<sub>2</sub> max:** \_\_\_\_/\_\_\_\_ mm Hg  
systolic diastolic

**11 Borg RPE score at VO<sub>2</sub> peak/VO<sub>2</sub> max:** \_\_\_\_\_ (6-20)

**12 Peak RER:** \_\_\_\_\_

**13 VE at VO<sub>2</sub> peak/VO<sub>2</sub> max:** \_\_\_\_\_ L/min

**14 VE/VO<sub>2</sub> at VO<sub>2</sub> peak/VO<sub>2</sub> 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 (Use codelist below)
_____ first middle last	<b>Start Date:</b> ____ / ____ / ____ day month year	<b>Start Time</b> ____ : ____ 00:00 to 23:59	_____
	<b>Stop Date:</b> ____ / ____ / ____ day month year	<b>Stop Time</b> ____ : ____ 00:00 to 23:59	

### 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?

☐ No

☐ Yes → If Yes: Were any Exclusion criteria met? ☐ No → Proceed with test  
☐ 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: ☐ Right ☐ 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:
<b>1 Normal saline</b>	_____ mm	_____ mm	<div><small>first middle last</small></div> (initials)	_____ mm	_____ mm	<div><small>first middle last</small></div> (initials)
<b>2 Tetanus toxoid (TT)</b> (check only one): <input type="checkbox"/> Tetanus toxoid (Sanofi-Pasteur) <input type="checkbox"/> Other: _____ Lot #: _____	_____ mm	_____ mm		_____ mm	_____ mm	
<b>3 Candida</b> (check only one): <input type="checkbox"/> Candin (AllerMed) <input type="checkbox"/> Other: _____ Lot #: _____	_____ mm	_____ mm		_____ mm	_____ mm	
<b>4 Trichophyton</b> (check only one): <input type="checkbox"/> Trichophyton Allergic Extract (AllerMed) <input type="checkbox"/> Other: _____ Lot #: _____	_____ mm	_____ mm		_____ mm	_____ mm	

**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

### 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"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Yes	_____	_____ <small>first middle last</small>
Blood	<input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Yes	_____	_____ <small>first middle last</small>
Oral glucose tolerance test (OGTT)	<input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> 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	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

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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
<del>Day 1 of menses (females only)</del>				
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>
<del>Hormone level blood draw 2 (females only)</del> <del>Progesterone level</del>				
Day 2	Date	Time	If Not Done, Reason (use codelist)	Staff Initials
<del>Date and time of last meal</del>				
<del>Hormone level blood draw 3 (females only)</del> <del>Progesterone level</del>				

### 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 (useodelist 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 #	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
<b>7</b> <small>(yesterday)</small>	____/____/____ <small>day month year</small>	____:____ to ____:____ 00:00 to 23:59	____:____ to ____:____ 00:00 to 23:59	____:____ to ____:____ 00:00 to 23:59	____:____ to ____:____ 00:00 to 23:59	____	____	____	____	____	____	____	____	____
<b>6</b>	____/____/____ <small>day month year</small>	____:____ to ____:____ 00:00 to 23:59	____:____ to ____:____ 00:00 to 23:59	____:____ to ____:____ 00:00 to 23:59	____:____ to ____:____ 00:00 to 23:59	____	____	____	____	____	____	____	____	____
<b>5</b>	____/____/____ <small>day month year</small>	____:____ to ____:____ 00:00 to 23:59	____:____ to ____:____ 00:00 to 23:59	____:____ to ____:____ 00:00 to 23:59	____:____ to ____:____ 00:00 to 23:59	____	____	____	____	____	____	____	____	____
<b>4</b>	____/____/____ <small>day month year</small>	____:____ to ____:____ 00:00 to 23:59	____:____ to ____:____ 00:00 to 23:59	____:____ to ____:____ 00:00 to 23:59	____:____ to ____:____ 00:00 to 23:59	____	____	____	____	____	____	____	____	____
<b>3</b>	____/____/____ <small>day month year</small>	____:____ to ____:____ 00:00 to 23:59	____:____ to ____:____ 00:00 to 23:59	____:____ to ____:____ 00:00 to 23:59	____:____ to ____:____ 00:00 to 23:59	____	____	____	____	____	____	____	____	____
<b>2</b>	____/____/____ <small>day month year</small>	____:____ to ____:____ 00:00 to 23:59	____:____ to ____:____ 00:00 to 23:59	____:____ to ____:____ 00:00 to 23:59	____:____ to ____:____ 00:00 to 23:59	____	____	____	____	____	____	____	____	____
<b>1</b> <small>(1 week ago)</small>	____/____/____ <small>day month year</small>	____:____ to ____:____ 00:00 to 23:59	____:____ to ____:____ 00:00 to 23:59	____:____ to ____:____ 00:00 to 23:59	____:____ to ____:____ 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*)?

- ☐<sub>1</sub> More  
☐<sub>2</sub> Less  
☐<sub>3</sub> 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?

- ☐<sub>0</sub> No  
☐<sub>1</sub> Yes

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

- ☐<sub>0</sub> No  
☐<sub>1</sub> Yes

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

- ☐<sub>0</sub> No  
☐<sub>1</sub> Yes

Center Number: \_\_\_\_ Participant Number: \_\_\_\_ Participant's Initials: first middle last

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

## Daily Home Weight Log

**Please complete this log in either blue or black ink.**

Day of week: _____	Day of week: _____	Day of week: _____	Day of week: _____	Day of week: _____	Day of week: _____
Date: _____ month / _____ day / _____ year	Date: _____ month / _____ day / _____ year	Date: _____ month / _____ day / _____ year	Date: _____ month / _____ day / _____ year	Date: _____ month / _____ day / _____ year	Date: _____ month / _____ day / _____ year
Time: <input type="text"/> _1 AM <input type="text"/> _2 PM _____ : _____ 00:00 to 11:59	Time: <input type="text"/> _1 AM <input type="text"/> _2 PM _____ : _____ 00:00 to 11:59	Time: <input type="text"/> _1 AM <input type="text"/> _2 PM _____ : _____ 00:00 to 11:59	Time: <input type="text"/> _1 AM <input type="text"/> _2 PM _____ : _____ 00:00 to 11:59	Time: <input type="text"/> _1 AM <input type="text"/> _2 PM _____ : _____ 00:00 to 11:59	Time: <input type="text"/> _1 AM <input type="text"/> _2 PM _____ : _____ 00:00 to 11:59
Weight: _____ . _____ lb	Weight: _____ . _____ lb	Weight: _____ . _____ lb	Weight: _____ . _____ lb	Weight: _____ . _____ lb	Weight: _____ . _____ lb
<b>Check scale memory</b>					

**Send Completed Logs to DCRI Only If Completed During DLW Periods**