



Draft

PRIDE

Participant ID #	Acrostic	Date of Visit		Staff ID #
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TWO INCONTINENCE QUESTIONNAIRE (2IQ) (Self-Administered)

Visit: ⁻⁴ ☐ Orientation Visit ⁻² ☐ SV1 **VISIT**

Instructions: Please use a black pen and fill in bubbles completely.

Please answer the following questions as best as you can.

During the **last 3 months**, have you leaked urine, even a small amount?

1 ☐ Yes

0 ☐ No

LEAK3M

Thank you. The questionnaire is completed.

1. During the **last 3 months**, have you leaked urine: (Please mark all that apply.)

1 ☐ When you were performing some physical activity such as coughing, sneezing, lifting or exercise? **1PHY**

1 ☐ When you had the urge or the feeling that you needed to empty your bladder but you could not get to the toilet fast enough? **1LATE**

1 ☐ **Without** either physical activity or a sense of urgency? **1WITHO**

1 ☐ Don't Know **1DK**

2. During the **last 3 months**, have you leaked urine **most often**: (Please mark one.)

2MOST

0 ☐ When you were performing some physical activity such as coughing, sneezing, lifting or exercise?

1 ☐ When you had the urge or the feeling that you needed to empty your bladder but you could not get to the toilet fast enough?

2 ☐ **Without** either physical activity or a sense of urgency?

3 ☐ **About equally** as often with a physical activity as with a sense of urgency?

8 ☐ Don't Know

ALL FIELDS START WITH "TQ"





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BOWEL HABITS QUESTIONNAIRE (Self-Administered)

VISIT

Visit: ☒ SV2 ☐ RV ☒ 6 months ☒ 12 months ☒ 18 months

Instructions: Please use a black pen and fill in bubbles completely.

1. **During the past 3 months**, how many times did you typically have a bowel movement each week?

times per week

BMPW

2. **During the past 3 months**, how much time did you typically spend on the toilet trying to have a bowel movement?

0 ☐ Less than 5 minutes

1 ☐ 5 to 10 minutes

2 ☐ 11 to 30 minutes

3 ☐ More than 30 minutes

BMTIME

3. **During the past 3 months**, were your bowel movements typically liquid or formed (solid)?

0 ☐ Liquid

1 ☐ Formed (solid) →

BMSOLI

3a. **IF FORMED**, what did your bowel movement typically look like?

0 ☐ Soft → Go to Question 4.

BMFOLO

1 ☐ Hard → Go to Question 3b.

2 ☐ Very hard or pellet like → Go to Question 3b.

3b. **If you had hard, very hard or pellet like stools**, how often was it hard, very hard or pellet like?

0 ☐ Rarely

1 ☐ Occasionally

2 ☐ Usually

3 ☐ Always

BMHAF

ALL FIELDS START WITH "BH"





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BOWEL HABITS QUESTIONNAIRE

(Self-Administered)

VISIT

Visit: ☒ SV2 ☐ RV ☐ 6 months ☒ 12 months ☐ 18 months

4. During the past 3 months, typically, how often have you... (Please mark <u>one</u> in each row.)	Never 0	Rarely 1	Occasionally 2	Usually 3	Always 4
A. Not been able to pass a bowel movement when you tried? 4PBOW	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. Had a feeling that you did not completely empty your bowels at the end of a bowel movement? 4NEMP	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. Had to strain for more than 10 minutes to pass a bowel movement? 4STRAIN	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D. Had pain in your anus or rectum when passing a bowel movement? 4PANUS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
E. Had bloating or a feeling of too much gas in your stomach/abdomen? 4BLOAT	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F. Had pain in your stomach/abdomen? 4PAINA	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

5. During the past 3 months, how often did you typically use diet, medications or aids to help you have a bowel movement? (Please mark <u>one</u> in each row.)	Never 0	Less than monthly 1	Monthly (once or more each month) 2	Weekly (once or more each week) 3	Daily (once or more each day) 4
A. Dietary Fiber: specifically to help have a bowel movement (such as bran, prunes, vegetables) 5DFIB	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. Supplemental Fiber: (such as Metamucil, Citrucel, Konsyl, Fibercon, Benefiber) 5SFIB	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. Stool softeners: (such as Colace, Mineral Oil) 5SS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D. Laxatives: (such as Ducolax, ExLax, Correctol, Milk of Magnesia, Miralax, Golytely) 5LAX	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

ALL FIELDS START WITH "B"





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BOWEL HABITS QUESTIONNAIRE (Self-Administered)

VISIT Visit: ☐ SV2 ☐ RV ☐ 6 months ☐ 12 months ☐ 18 months

5. (Continued) During the past 3 months, how often did you typically use diet, medications or aids to help you have a bowel movement? (Please mark <u>one</u> in each row.)	Never 0	Less than monthly 1	Monthly (once or more each month) 2	Weekly (once or more each week) 3	Daily (once or more each day) 4
E. Enemas 5ENEM	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F. Finger in vagina 5FVAG	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
G. Finger in anus/rectum 5FANU	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
H. Other 5OTH	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

6. During the past 3 months, typically, how often were you constipated? (Please mark one.)

- 0** ☐ Never → Go to Question 10.
1 ☐ Less than monthly → Go to Question 10.
2 ☐ Monthly (once or more each month) **0CON**
3 ☐ Weekly (once or more each week)
4 ☐ Daily (once or more each day)

7. For how long have you been constipated **at least once per month?**

- 0** ☐ Less than 1 year
1 ☐ 1 to 5 years
2 ☐ 6 to 10 years **5LCON**
3 ☐ 11 to 20 years
4 ☐ More than 20 years

ALL FIELDS START WITH "BJ"





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BOWEL HABITS QUESTIONNAIRE**(Self-Administered)****VISIT**Visit: ☒ SV2 ☐ RV ☐ 6 months ☒ 12 months ☐ 18 months8. During the past 3 months, how much did constipation **bother** you?

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

COBO9. During the past 3 months, how much did constipation **affect your day-to-day activities?**

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

COAF

	0	1	2	3	4
	Never	Less than monthly	Monthly (once or more each month)	Weekly (once or more each week)	Daily (once or more each day)
10. During the past 3 months, how often did you experience any of the following unexpected or accidental bowel leakage , even a small amount? (Please mark <u>one</u> in each row.)					
A. Unexpected or accidental gas that you cannot control. LGAS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. Unexpected or accidental mucus (clear or cloudy discharge) that you cannot control. LMUC	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. Unexpected or accidental liquid bowel movement that you cannot control. LLIQ	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D. Unexpected or accidental solid bowel movement that you cannot control. LSOL	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>





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CHANGE OF STATUS FORM**VISIT****6****12****18**Visit: ☐ 6 months ☐ 12 months ☐ 18 months

Instructions: Please use a black pen and fill in bubbles completely. Use ALL CAPITAL LETTERS to print words.

Participant's Status: Please select either 1 or 2.

☐ 1. Participant wishes to rejoin PRIDE.

REJDT

A. Participant resumed participation in the study on

 / /

Month

Day

Year

B. Primary reason for resuming participation:

0 ☐ Incontinence got worse

1 ☐ Regained weight

REJWHY

2 ☐ Family/schedule/transportation issues resolved

3 ☐ Other: (Please specify.)

REJSPE

☐ 2. Participant wishes to discontinue PRIDE for the second time (permanent termination).

DCDT

A. Participant discontinued the study again on

 / /

Month

Day

Year

B. Primary reason for resuming participation:

0 ☐ Illness/medical condition: (Please specify.)

1 ☐ Unwilling to follow program/withdrew consent

DILSPE

2 ☐ No change in incontinence symptoms

3 ☐ No change in weight

4 ☐ Moved from the area

5 ☐ Transportation problems

6 ☐ Schedule conflicts

7 ☐ Family problems

8 ☐ Other: (Please specify.)

DCSPE





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CYSTOMETROGRAM (CMG) AND LEAK POINT PRESSURES (LPP)

VISITVisit: ☐ UDS Baseline ☐ UDS 6 months**Instructions:** Please use a black pen and fill in bubbles completely.

1. Was the CMG completed with participant sitting at 45° angle (required by protocol)?

1 ☐ Yes ☐ No **CMGO**2. Please specify the catheter diameter: **CDIA** French (8 French is recommended)3. **Pves** at baseline: **cm H₂O** **PVES**4. **Pabd** at baseline: **cm H₂O** **PABD**5. Bladder volume at first desire to void: **ml** **BLVOLF**6. Bladder volume at strong desire to void: **ml** **BLVOLS****PROLAPSE STATUS**

7. Is there a Stage III or IV anterior prolapse?

☐ Yes (skip to question #10) ☐ No **PROL****LPP MEASURES FOR PATIENT WITHOUT ANTERIOR PROLAPSE STAGE III OR IV**

8. Did leakage occur with Valsalva? (To code this item YES, leakage must occur with Valsalva at least twice at the same volume level.)

☐ Yes ☐ No (skip to question #15) **NLEAK**9. At what volume? **ml** **NLEAKV**9a. Raw Pves at 1st leakage: **cm H₂O** **NRPA**9b. Raw Pves at 2nd leakage: **cm H₂O** **NRPB**9c. Raw Pves at 3rd leakage: **cm H₂O** **NRPC**

SKIP TO 15 if leakage occurs at least twice at the same volume with Valsalva maneuvers





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CYSTOMETROGRAM (CMG) AND LEAK POINT PRESSURES (LPP)

VISITVisit: ☒ UDS Baseline ☐ UDS 6 months

LPP MEASURES FOR PATIENT WITH ANTERIOR PROLAPSE STAGE III OR IV

10. Did leakage occur with Valsalva? (To code this item YES, leakage must occur with Valsalva at least twice at the same volume level.)

☒ Yes ☐ No (Go to question #12) **WLEAK**

11. At what volume? **WLEAKV**
ml

11a. Raw Pves at 1st leakage: **WRPA** cm H₂O →

11b. Raw Pves at 2nd leakage: **WRPB** cm H₂O →

11c. Raw Pves at 3rd leakage: **WRPC** cm H₂O →

Leakage must occur at
least twice with
Valsalva maneuvers at
the same volume

MEASURES COMPLETED AFTER PROLAPSE REDUCTION

12. The prolapse was reduced by:

- ☐ Rectal Swab (required by protocol) **ARED**
☒ Ring forcep
☐ Speculum
☐ Other

13. Did leakage occur with Valsalva with reduction? (To code this item YES, leakage must occur with Valsalva at least twice at the same volume level.)

☒ Yes ☐ No (skip to question #15) **ALEAK**

14. At what volume? ml **ALEAKV**

14a. Raw Pves at 1st leakage: **ARPA** cm H₂O →

14b. Raw Pves at 2nd leakage: **ARPB** cm H₂O →

14c. Raw Pves at 3rd leakage: **ARPC** cm H₂O →

SKIP TO 15 if leakage
occurs at least twice at
the same volume with
Valsalva maneuvers



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CYSTOMETROGRAM (CMG) AND LEAK POINT PRESSURES (LPP)

VISITVisit: **1** ☐ UDS Baseline ☒ UDS 6 months

15. Bladder volume at MCC: ml **BVMCC**
16. **1** Did leakage occur with cough? **LEAKML**
☐ No ☐ Yes **MCCLEA** → If yes, enter bladder volume at leakage ml
17. **Pves** at MCC: cm H₂O **PVESM**
18. **Pabd** at MCC: cm H₂O **PABDM**
19. Was there detrusor overactivity?
☒ Yes ☐ No **0** → form completed **DEOV**
20. Record volume at each occurrence of detrusor overactivity and indicate if overactivity was associated w/ leakage.

Occurrence	Recorded Volume	Leakage?
20a. Occurrence 1:	O1V <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> ml	O1L <input type="radio"/> Yes <input type="radio"/> No 1 0
20b. Occurrence 2:	O2V <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> ml	O2L <input type="radio"/> Yes <input type="radio"/> No 1 0
20c. Occurrence 3:	O3V <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> ml	O3L <input type="radio"/> Yes <input type="radio"/> No 1 0





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COST ANALYSIS (Follow-up) (Self-Administered)

VISIT

Visit: ☒ 6 months ☐ 12 months ☐ 18 months

Instructions: Please use a black pen and fill in all bubbles completely.

1. **During the past 3 months**, how many times have you done each of the following (do not include calls or visits for PRIDE):

a. Called and talked to a health care provider?

1CALL
time (s)

b. Had a regularly scheduled out-patient healthcare visit(s)?

1SCHED
time (s)

c. Had urgent healthcare visit(s)?

1URGE
time (s)

d. Had emergency room visit(s)?

1ER
time (s)

2. **During the past 3 months**, how many days have you lost from school, work, or household activities due to illness, injury or medical care visits (including visits related to PRIDE)? (round to the nearest half day (.5))

day (s) **LOST**

3. When you go to doctor or nurse visits, how often does your spouse, family or friends go with you? (Do not include visits for PRIDE)

6 ☐ Always

5 ☐ Almost always

4 ☐ Usually **SPOGW**

3 ☐ Half the time or sometimes

2 ☐ Rarely

1 ☐ Almost never

0 ☐ Never





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COST ANALYSIS (Follow-up) (Self-Administered)

VISITVisit: **6** ☐ 6 months **12** ☐ 12 months **18** ☐ 18 months

Please consider the past 3 months when you respond to these questions.

4. Typically, how many hours per week do you spend shopping for food or preparing food for yourself?

hours per week

HOPSE

5. Typically, how many hours per week do your spouse, family, and friends spend shopping for or preparing foods for you?

hours per week

HOPOTH

6. **Compared to when you started in PRIDE**, have the costs of the foods that you have eaten at home:

- 4 ☐ Increased a lot
 3 ☐ Increased some
 2 ☐ Stayed about the same
 1 ☐ Decreased some
 0 ☐ Decreased a lot

HFCOST

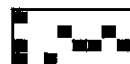
7. **Compared to when you started in PRIDE**, has the number of meals that you have eaten in (or taken out from) fast-food restaurants:

- 4 ☐ Increased a lot
 3 ☐ Increased some
 2 ☐ Stayed about the same
 1 ☐ Decreased some
 0 ☐ Decreased a lot

COFOOD

8. **Compared to when you started in PRIDE**, has the number of meals that you have eaten in (or taken out from) non-fast-food restaurants:

- 4 ☐ Increased a lot
 3 ☐ Increased some
 2 ☐ Stayed about the same
 1 ☐ Decreased some
 0 ☐ Decreased a lot

NFOUT



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COST ANALYSIS (Follow-up) (Self-Administered)

VISITVisit: ☒ 6 months ☒ 12 months ☐ 18 months

Please consider the past 3 months when you respond to these questions.

9. Typically, how many hours per week do you spend exercising?

hours per week

EXERSE

10. Typically, how many hours per week do your spouse, family, and friends spend exercising with you?

hours per week

EXERSP

11. Do you typically use a car or public transportation to get to an exercise, sports, or physical activity in which you participate?

☐ Yes

1

☐ No

0

CAR

12. Think of all the exercises and physical activities that you have done during the past 3 months for your health and rate them, as a group, according to the level of pleasure or satisfaction that you get from them. Please select one of the following:

2 ☐ Like/enjoy/get satisfaction from activities

1 ☐ Neutral

0 ☐ Don't like/enjoy/get satisfaction from activities

SATIS

13. If you were not spending your time exercising, what other activity would you normally be doing?

3 ☐ Leisure activities

2 ☐ Work

1 ☐ Household work

0 ☐ Other

OACT



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COST ANALYSIS (Follow-up) (Self-Administered)

VISIT

Visit: ⁶☐ 6 months ¹²☐ 12 months ¹⁸☐ 18 months

Please consider the past 3 months when you respond to these questions.

14. Typically, when you go to PRIDE visits, how often does your spouse, family or friends go with you?

- 6** ☐ Always
5 ☐ Almost always
4 ☐ Usually
3 ☐ Half the time/Sometimes
2 ☐ Rarely
1 ☐ Almost never
0 ☐ Never

SPOUSE

15. Typically, what method of travel did you use most often to get to PRIDE visits?

- 6** ☐ Your own car
5 ☐ A friend's car
4 ☐ Bus
3 ☐ Train
2 ☐ Taxi
1 ☐ Walk from home
0 ☐ Other

TRAVEL

16. What is your estimated average round trip travel time to PRIDE visits?

hours minutes

TTHOUR**TTMIN**

17. About how many miles, on average, do you travel round trip to PRIDE visits?

miles

RTMILE

18. After you arrive to the PRIDE visit, about how much time, on average, do you spend in the clinic both waiting and in study-related activities?

WHOUR hours **WMIN** minutes





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COST ANALYSIS (Follow-up)

(Self-Administered)

VISIT

Visit: ☐ 6 months ☐ 12 months ☐ 18 months

19. During the past 3 months, have you received unpaid in-home assistance with activities such as eating, going to the toilet, dressing, bathing, moving, changing positions, or walking across a room?

0 ☐ No

▶ go to question 20

1

☐ Yes

EUP

19a. If yes, how often **in the past month** did you have unpaid help with these activities?

4 ☐ Every day3 ☐ Several times a week2 ☐ About once a week1 ☐ Less than once a week0 ☐ Not at all

EUPOF

19b. On the days you had unpaid help **in the past month**, about how many hours did you have this help?

0 ☐ Less than 1 hour1 ☐ 1-2 hours2 ☐ more than 2-3 hours3 ☐ more than 3-4 hours4 ☐ More than 4 hours

EUPHO

20. During the past 3 months, have you received in-home assistance with activities such as eating, going to the toilet, dressing, bathing, moving, changing positions, or walking across a room for which the helper was paid?

0 ☐ No

▶ go to question 21

1 ☐ Yes▶ How much was the helper paid in **the past month** by you or any other source?

EPAY

EPAYAM

\$ in the past month





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COST ANALYSIS (Follow-up) (Self-Administered)

VISIT

 Visit: ☒ 6 ☐ 12 ☐ 18
 months months months

21. During the past 3 months, have you received unpaid in-home assistance with preparing meals, grocery shopping, making phone calls, taking medications, or managing money?

0 ☐ No

▶ go to question 22

1 ☐ Yes**MUP**

21a. If yes, how often in the past month did you have unpaid help with these activities?

4 ☐ Every day3 ☐ Several times a week2 ☐ About once a week1 ☐ Less than once a week0 ☐ Not at all**MUPOF**

21b. On the days you had unpaid help in the past month, about how many hours did you have this help?

0 ☐ Less than 1 hour1 ☐ 1-2 hours2 ☐ More than 2-3 hours3 ☐ More than 3-4 hours4 ☐ More than 4 hours**MUPHO**

22. During the past 3 months, have you received in-home assistance with preparing meals, grocery shopping, making phone calls, taking medications, or managing money for which the helper was paid?

0 ☐ No

▶ go to question 23

1 ☐ Yes**MPAY**

▶ How much was the helper paid in the past month by you or any other source?

 \$ in the past month
MPAYAM




Draft

Participant ID #	Acrostic	Date of Visit			Staff ID #
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
ID	ACROS	DATE			STFID

COST ANALYSIS (Follow-up) (Self-Administered)

VISITVisit: ☒ 6 months ☐ 12 months ☐ 18 months

23. During the past 6 months, have you purchased any of the following items to help you prepare the foods you eat?

	Yes	No
a. Air popper (popcorn)	<input type="radio"/> Yes	<input type="radio"/> No
b. Blender	<input type="radio"/> Yes	<input type="radio"/> No
c. Cookbooks	<input type="radio"/> Yes	<input type="radio"/> No
d. Cooking videos	<input type="radio"/> Yes	<input type="radio"/> No
e. Food scale	<input type="radio"/> Yes	<input type="radio"/> No
f. Freezer	<input type="radio"/> Yes	<input type="radio"/> No
g. Microwave	<input type="radio"/> Yes	<input type="radio"/> No
h. Mixer	<input type="radio"/> Yes	<input type="radio"/> No
i. Steamer	<input type="radio"/> Yes	<input type="radio"/> No
j. Wok	<input type="radio"/> Yes	<input type="radio"/> No
k. Other	<input type="radio"/> Yes	<input type="radio"/> No

yes=1, no =0

POP**BLEND****COOKB****COOKV****FSCALE****FREEZ****MICROW****MIXER****STEAM****WOK****OTH****PAYTOT**

23a. If yes, how much did you pay in total for all items? \$ dollars

24. During the past 3 months, have you purchased any exercise shoes (walking, running, or sport specific shoes)?

☐ Yes

24a. If yes, how many pairs did you buy? pairs **NUMPAI**

24b. How much did you pay in total? \$ dollars **PAY**

P U R E X E☐ No

▶ go to question 25





Draft

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ID	ACROS	Month	Day	Year	STFID

COST ANALYSIS (Follow-up) (Self-Administered)

VISITVisit: ☒ 6 months ☒ 12 months ☐ 18 months

25. During the past 6 months, have you purchased any of the following items to promote your fitness, health, and well being?

	Yes	No
a. Bicycle	<input type="radio"/> Yes	<input type="radio"/> No
b. Stationary bike	<input type="radio"/> Yes	<input type="radio"/> No
c. Exercise videos/DVDs	<input type="radio"/> Yes	<input type="radio"/> No
d. Step (for aerobics)	<input type="radio"/> Yes	<input type="radio"/> No
e. Stair master	<input type="radio"/> Yes	<input type="radio"/> No
f. Free weights (dumbbells)	<input type="radio"/> Yes	<input type="radio"/> No
g. Rowing machine	<input type="radio"/> Yes	<input type="radio"/> No
h. Treadmill	<input type="radio"/> Yes	<input type="radio"/> No
i. Skiing machine	<input type="radio"/> Yes	<input type="radio"/> No
j. Home gym	<input type="radio"/> Yes	<input type="radio"/> No
k. Ice skates	<input type="radio"/> Yes	<input type="radio"/> No
l. Roller blades or roller-skates	<input type="radio"/> Yes	<input type="radio"/> No
m. Snow shoes	<input type="radio"/> Yes	<input type="radio"/> No
n. Downhill skis or snowboard	<input type="radio"/> Yes	<input type="radio"/> No
o. Cross country skis	<input type="radio"/> Yes	<input type="radio"/> No
p. Golf clubs	<input type="radio"/> Yes	<input type="radio"/> No
q. Tennis racket	<input type="radio"/> Yes	<input type="radio"/> No
r. Jump rope	<input type="radio"/> Yes	<input type="radio"/> No
s. Swimsuit	<input type="radio"/> Yes	<input type="radio"/> No
t. Other	<input type="radio"/> Yes	<input type="radio"/> No

yes=1, no =0

FBIC**FSTAB****FEXERV****FSTEP****FSTRMS****FDUMB****FROW****FTREAD****FSKIM****FHGYM****FICES****FROLLB****FSNOWS****FDWNSK****FCCSKI****FGOLFC****FTENNR****FJUMPR****FSWIMS****FOTH**



Draft

PRIDE

Participant ID #	Acrostic	Date of Visit		Staff ID #
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ID	ACROS	Month	DATE	Year
				STFID

COST ANALYSIS (Baseline) (Self-Administered)

Visit: ☒ Screening ☐ Randomization **VISIT**

Instructions: Please use a black pen and fill in all bubbles completely.

1. **During the past 3 months**, how many times have you done each of the following (do not include calls or visits for PRIDE):

a. Called and talked to a health care provider?

 1CALL
time (s)

b. Had a regularly scheduled out-patient healthcare visit(s)?

 1SCHED
time (s)

c. Had an urgent healthcare visit(s)?

 1URGE
time (s)

d. Had an emergency room visit(s)?

 1ER
time (s)

2. **During the past 3 months**, how many days have you lost from school, work, or household activities due to illness, injury or medical care visits (including visits related to PRIDE)? (Round to the nearest half day (.5))

 LOST
day (s)

3. When you go to doctor or nurse visits, how often does your spouse, family or friends go with you? (Do not include visits for PRIDE.)

- 6 ☐ Always **SPOGW**
 5 ☐ Almost always
 4 ☐ Usually
 3 ☐ Half the time or sometimes
 2 ☐ Rarely
 1 ☐ Almost never
 0 ☐ Never





Draft

Participant ID #	Acrostic	Date of Visit		Staff ID #
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ID	ACROS	Month	DATE Day	Year STFID

COST ANALYSIS (Baseline) (Self-Administered)

Visit: **-3** ☐ Screening ☒ Randomization

VISIT

Please consider the past 3 months when you respond to these questions.

4. Typically, how many hours per week do you spend shopping for food or preparing food for yourself?

hours per week

HOPSE

5. Typically, how many hours per week do your spouse, family, and friends spend shopping for or preparing foods for you?

hours per week

HOPOTH

6. Typically, how many hours per week do you spend exercising?

hours per week

EXERSE

7. Typically, how many hours per week do your spouse, family, and friends spend exercising with you?

hours per week

EXERSP

8. Do you typically use a car or public transportation to get to an exercise, sports, or physical activity in which you participate?

☐ Yes

1

☐ No

0

CAR





Draft

Participant ID #	Acrostic	Date of Visit			Staff ID #	
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	/	<input type="text"/> <input type="text"/>	/	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
ID	ACROS	Month		Day		STFID

COST ANALYSIS (Baseline) (Self-Administered)

Visit: **3** ☐ Screening ☒ Randomization

VISIT

9. During the past 3 months, have you purchased any exercise shoes (walking, running, or sport specific shoes)?

☐ Yes

☐ No

P U R E X E

1 ↓

0

9a. If yes, how many pairs did you buy?

pairs

NUMPAI

9b. How much did you pay in total?

dollars

PAY

10. Think of all the exercises and physical activities that you have done during the past 3 months for your health and rate them, as a group, according to the level of pleasure or satisfaction that you get from them. Please select one of the following:

2 ☐ Like/enjoy/get satisfaction from activities

1 ☐ Neutral

SATIS

0 ☐ Don't like/enjoy/get satisfaction from activities

11. If you were not spending your time exercising, what other activity would you normally be doing?

3 ☐ Leisure activities

2 ☐ Work

1 ☐ Household work

OACT

0 ☐ Other





Draft

Participant ID #	Acrostic	Date of Visit		Staff ID #
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ID	ACROS	Month DATE	Year	STFID

COST ANALYSIS (Baseline) (Self-Administered)

Visit: -3 ☐ Screening 6 ☐ Randomization

VISIT

12. **During the past 3 months**, have you received unpaid in-home assistance with activities such as eating, going to the toilet, dressing, bathing, moving, changing positions, or walking across a room?

☐ No ► go to question 13

☒ Yes
EUP

12a. If yes, how often **in the past month** did you have unpaid help with these activities?

- ☒ Every day **EUPOF**
☐ Several times a week
☐ About once a week
☐ Less than once a week
☐ Not at all

12b. On the days you had unpaid help **in the past month**, about how many hours did you have this help?

- ☒ Less than 1 hour **EUPHO**
☐ 1-2 hours
☐ more than 2-3 hours
☐ more than 3-4 hours
☐ More than 4 hours

13. **During the past 3 months**, have you received in-home assistance with activities such as eating, going to the toilet, dressing, bathing, moving, changing positions, or walking across a room for which the helper was paid?

☐ No ► go to question 14

☒ Yes
EPAY

► How much was the helper paid **in the past month** by you or any other source?

\$ in the past month

EPAYAM





Draft

PRIDE

Participant ID #	Acrostic	Date of Visit	Staff ID #
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
ID	ACROS	Month DATE Year	STFID

COST ANALYSIS (Baseline) (Self-Administered)

Visit: -3 ☐ Screening ☒ Randomization **VISIT**

14. During the past 3 months, have you received unpaid in-home assistance with preparing meals, grocery shopping, making phone calls, taking medications, or managing money?

0 ☐ No

► go to question 15

1

☐ Yes

MUP

► 14a. If yes, how often **in the past month** did you have unpaid help with these activities?

4 ☐ Every day

3 ☐ Several times a week

MUPOF

2 ☐ About once a week

1 ☐ Less than once a week

0 ☐ Not at all

14b. On the days you had unpaid help **in the past month**, about how many hours did you have this help?

0 ☐ Less than 1 hour

1 ☐ 1-2 hours

MUPHO

2 ☐ More than 2-3 hours

3 ☐ More than 3-4 hours

4 ☐ More than 4 hours

15. During the past 3 months, have you received in-home assistance with preparing meals, grocery shopping, making phone calls, taking medications, or managing money for which the helper was paid?

0 ☐ No

► questionnaire completed

1

☐ Yes

► How much was the helper paid **in the past month** by you or any other source?

MPAY

\$ in the past month

MPAYAM

CE

Draft





Draft

Participant ID #	Acroscopic	Date of Visit			Staff ID #
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ID	ACROS	Month	Day	Year	STFID

DEMOGRAPHICS FORM

(Self-Administered)

Visit: ☐ Screening -3**VISIT**

Instructions: Please use a black pen and fill in bubbles completely.

1. What is your Date of Birth? / / **BDATE**
 Month Day Year

2. What is the highest level of education that you have completed? (Please mark one.)

0 ☐ No formal schooling

1 ☐ 5th grade or less

2 ☐ 6th to 11th grade

3 ☐ High School Graduate (grade 12) or equivalent

EDUC

4 ☐ Some College, Vocational School, or Junior College

5 ☐ College Degree (4 year)

6 ☐ Graduate or Professional Degree

3. Which of the following best describes your current relationship status? (Please mark one.)

0 ☐ Married

1 ☐ Living with significant other/partner

STAT

2 ☐ Living with a friend

3 ☐ Significantly involved with a partner, but not living together

4 ☐ Single / not significantly involved / widowed / divorced

4. Which of the following best describes your usual activities during the past 3 months? (Please mark one.)

0 ☐ Employed in a job or business (including unpaid work in a family business)

1 ☐ Engaged primarily in caring for my own house (housework)

WORKH

2 ☐ Self-employed (not including housework)

3 ☐ Volunteer Work

4 ☐ Unemployed

ALL FIELDS START WITH "DE"

5 ☐ Retired





Draft

PRIDE

Participant ID #	Acrostic	Date of Visit			Staff ID #
<input type="text"/> ID	<input type="text"/> ACROS	<input type="text"/> / <input type="text"/> / <input type="text"/> Month DATE Year	<input type="text"/> STFID		

VOIDING DIARY DATA ENTRY FORM

VISIT: ☐ **3** Screening ☐ **0** RV ☐ **3** months ☐ **6** 6 months ☐ **12** 12 months ☐ **18** 18 months

Instructions: Please use a black pen.

Date of Day 1: / / **FDDATE**
Month Day Year

DAY 1

	Urinations in Toilet	Urine Leakages	Reason for Leakage		
			Urge	Stress	Other
DAYTIME Total:	<input type="text"/> DUT1	<input type="text"/> DUL1	<input type="text"/> DUR1	<input type="text"/> DST1	<input type="text"/> DOT1
NIGHTTIME Total:	<input type="text"/> NUT1	<input type="text"/> NUL1	<input type="text"/> NUR1	<input type="text"/> NST1	<input type="text"/> NOT1

DAY 2

	Urinations in Toilet	Urine Leakages	Reason for Leakage		
			Urge	Stress	Other
DAYTIME Total:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
NIGHTTIME Total:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**DAY 2 AND 3 CODED LIKE DAY 1, EXCEPT END
WITH 2 FOR DAY 2 AND 3 FOR DAY 3**

	Urinations in Toilet	Urine Leakages	Reason for Leakage		
			Urge	Stress	Other
DAYTIME Total:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
NIGHTTIME Total:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>





Draft

PRIDE

Participant ID #	Acrostic	Date of Visit			Staff ID #
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/>
ID	ACROS	Month	DATE	Year	STFID

VOIDING DIARY DATA ENTRY FORM

VISIT: ☐ Screening ☐ RV ☒ 3 months ☐ 6 months ☐ 12 months ☐ 18 months

DAY 4-7 CODED LIKE DAY 1, EXCEPT END WITH DAY NUMBER (EG 4, 5 6, OT 7, INSTEAD OF 1)

	Urinations in Toilet	Urine Leakages	Urge	Stress	Other
DAYTIME Total:	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
NIGHTTIME Total:	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>

DAY 5

	Urinations in Toilet	Urine Leakages	Urge	Stress	Other
DAYTIME Total:	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
NIGHTTIME Total:	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>

DAY 6

	Urinations in Toilet	Urine Leakages	Urge	Stress	Other
DAYTIME Total:	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
NIGHTTIME Total:	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>

DAY 7

	Urinations in Toilet	Urine Leakages	Urge	Stress	Other
DAYTIME Total:	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
NIGHTTIME Total:	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>





Draft

Participant ID #	Acroscopic	Date of Visit	Staff ID #
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ID	ACROS	Month / Day / Year	STFID

DIPSTICK URINALYSIS FORM

VISIT

-2

-1

1

7

 Visit: ☐ SV1 ☐ SV2 ☐ UDS Baseline ☐ UDS 6 months

Instructions: Please use a black pen and fill in bubbles completely.

1. Was dipstick urinalysis done?

☒ Yes

0

☐ No

DIP

Collection Date:

<input type="text"/> <input type="text"/>	/	<input type="text"/> <input type="text"/>	/	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Month		Day		Year

CDATE

 If not done by RV, then
participant is **NOT ELIGIBLE**
**YES CODED AS 1, NO
CODED AS 0**

2. Leukocyte esterase:

LEU

☒ Negative

☐ Trace → **NOT ELIGIBLE. Referred for treatment?** ☐ Yes ☐ No

LEUT

☐ Small (+) → **NOT ELIGIBLE. Referred for treatment?** ☐ Yes ☐ No

LEUS

☐ Moderate (++) → **NOT ELIGIBLE. Referred for treatment?** ☐ Yes ☐ No

LEUM

☐ Large (+++) → **NOT ELIGIBLE. Referred for treatment?** ☐ Yes ☐ No

LEUL

3. Blood:

BOLLOD

☒ Negative

☐ Trace

☐ Moderate → **NOT ELIGIBLE. Referred for treatment?** ☐ Yes ☐ No

BLM

☐ Large → **NOT ELIGIBLE. Referred for treatment?** ☐ Yes ☐ No

BLL

4. Hemolyzed blood:

HEMBLO

☒ Negative

☐ Trace

☐ Small (+) → **NOT ELIGIBLE. Referred for treatment?** ☐ Yes ☐ No

HEMS

☐ Moderate (++) → **NOT ELIGIBLE. Referred for treatment?** ☐ Yes ☐ No

HEMM

☐ Large (+++) → **NOT ELIGIBLE. Referred for treatment?** ☐ Yes ☐ No

HEML





Draft

Participant ID #	Acrostic	Date of Visit	Staff ID #
<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>
ID	ACROS	Month Day Year DATE	STFID

EXIT QUESTIONNAIRE - Part 2**VISIT**Visit: **18** 18 months**Instructions:** Please use a black pen and fill in bubbles completely.

1. Have you actively participated in any weight loss programs in the past year?

1 ☐ Yes 0 ☐ No → **Go to Question 2. WLP**

1a. If yes, what program did you join? (Check all that apply)

1 ☐ Jenny Craig **WLPJC**1 ☐ WeightWatchers **WLPWW**1 ☐ NutriSystem **WLPNS****WLPOT**1 ☐ Other-specify:**WLPOTS**1 ☐ Don't Know**WLPDK**

2. Are you currently taking any prescription medications for weight loss?

1 ☐ Yes 0 ☐ No → **Go to Question 3. PMWL**

2a. If yes, what is the name of the medication?

PMWLNA

3. Have you had any surgery or other procedures for weight loss in the past 18 months?

1 ☐ Yes 0 ☐ No → **Go to Question 4. SPWL**

3a. If yes, what is the name of the procedure?

SPWLNA

4. Are you currently taking any prescription medications for incontinence?

1 ☐ Yes 0 ☐ No → **Go to Question 5. PMIN**

4a. If yes, what is the name of the medication?

PMINNA**ALL FIELDS START WITH "EX"**



Draft

PRIDE

Participant ID #	Acrostic
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ID	ACROS



EXIT QUESTIONNAIRE - Part 2

VISIT

Visit: 8 months

5. Have you had any surgery or procedure for incontinence in the past year?

1

0 ☐ Yes ☐ No → **This Questionnaire is complete.**
SGIN

5a. If yes, what was the procedure called? (please check only one)

SGINNA

0 ☐ Burch, Marshal-Marchetti-Krantz (MMK) or Retropubic suspension

1 ☐ Sling, Retropubic sling, Abdominal Vaginal Sling

2 ☐ Tension-free Vaginal Tape (TVT, TOT, or TVTO)

3 ☐ Needle Suspension (Stamey or Peyera procedure)

4 ☐ Anterior repair, Kelly plication, Cystocele repair, Anterior colporrhaphy, Urethropexy

5 ☐ Other - specify:

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SGINNSP

8 ☐ Don't Know

ALL FIELDS START WITH "EY"





Draft

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HEALTH HISTORY (Self-Administered)

VISITVisit: **3** Screening

Instructions: Please use a black pen and fill in bubbles completely.

1. Have you smoked 100 cigarettes (about 5 packs) or more in your entire life?

SMOKE **1** ☒ Yes ☐ No

2. Do you smoke cigarettes now?

SMNOW **1** ☒ Yes ☐ No

SMPDA

2a. If yes, on average, about how many cigarettes per day

3. Do you drink alcoholic beverages? (Alcoholic beverages would be 12 ounces of beer, 4 ounces of wine, or 1 shot (1.5 ounces) of liquor.)

ALUSE **1** ☒ Yes ☐ No → **Skip to Question #5**

3a. If yes, which of these statements comes closest to describing how often you drank alcoholic beverages in the past 30 days?

0 ☐ Every day

1 ☐ 5-6 days per week

2 ☐ 3-4 days per week

3 ☐ 1-2 days per week

4 ☐ 2-3 times in the past 30 days

5 ☐ Once in the past 30 days

6 ☐ Not at all in the past 30 days → **Skip to Question #5**

SALOFT

4. In the past **1 month**, about how many drinks did you usually have on days when you drank alcoholic beverages? (One drink would be 12 ounces of beer, 4 ounces of wine, or 1 shot (1.5 ounces) of liquor.)

I have

ALMANY drinks per day on days when I drink alcoholic beverages.





Draft

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HEALTH HISTORY

(Self-Administered)

VISITVisit: ☒ Screening

5. Have you ever had an operation to unclog or bypass the arteries in your legs or groin (peripheral vascular disease or surgery)?

☐ Yes ☐ No ☐ Don't know

PVD

1 0 8

6. Has a doctor ever told you that you had a stroke, cerebral infarction, cerebrovascular accident, CVA, or a transient ischemic attack (TIA)?

☐ Yes ☐ No ☐ Don't know

CVA

1 0 8

7. Have you ever been pregnant (please include miscarriages and abortions)?

☐ Yes ☐ No ☐ Don't know

EPREG

↓

7a. How many times have you been pregnant (please include miscarriages and abortions)?

gravity
TOTPRE
total pregnancies

7b. How many times have you given birth?

LIVBIR
total live births

parity

8. When was your last menstrual period?

0 ☐ Less than 1 year ago

1 ☐ More than 1 year ago

8 ☐ Don't know

LMP

9. Have you ever had any of the following surgical procedures?

a. Hysterectomy (Uterus or womb removed) **HYST** 1 ☐ Yes 0 ☐ No 8 ☐ Don't know

b. Ovaries removed

OVAREM 1 ☐ Yes 0 ☐ No 8 ☐ Don't know

If yes, mark one of the following:

One ovary ☐ 1 **WOVR**

Both ovaries ☐ 2

c. Surgery for 'dropped' or prolapsed female/pelvic organs (bladder, uterus, vagina, rectum)

1 ☐ Yes 0 ☐ No 8 ☐ Don't know
PROLAP





Draft

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HEALTH HISTORY (Self-Administered)

VISITVisit: ☒ Screening

10. About how old were you when you first started to leak urine at least once a week, for 3 months in a row?

years old

AGELU

11. Where have you found information about urine leakage?
(Please mark all that apply.)

IDOC ☐ Doctor, nurse, other healthcare provider**IBOOK** ☐ Books, magazines or newspaper articles**ITV** ☐ TV ads**IPAM** ☐ Pamphlets**IWWW** ☐ Internet or world wide web**IOTH** ☐ Other sources**INO** ☐ I have not found information about urine leakage

**ALL BUBBLES
CODED AS 1**

12. Have you ever discussed your urine leakage with: (Please mark all that apply.)

DFR ☐ Friends**DREL** ☐ Relatives**DSPO** ☐ Husband/Spouse/Partner**DCHI** ☐ Children**DNO** ☐ I have not discussed my leakage with friends or family

**ALL BUBBLES
CODED AS 1**





Draft

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HEALTH HISTORY (Self-Administered)

VISITVisit: ☒ Screening

13. Have you ever discussed your urine leakage with your doctor or healthcare provider?
(Do not include discussion with our study staff)

DLMD1 ☐ Yes →

After discussing your urine leakage with your doctor or healthcare provider, did you have further evaluation or treatment for your urine leakage?

DLMDEV☐ Yes ☐ No

1 0

0

☐ No →

Please indicate all the reasons you did not discuss your urine leakage with a medical provider or did not seek medical help for your urine leakage. (*Please mark all that apply.*)

NMAN☐ I can manage the urine leakage on my own**NSMALL**☐ I consider it a "small" problem**NBOTH**☐ My urine leakage didn't bother me**NNORM**☐ I thought it was a normal part of aging**NPUTUP**☐ I tend to put up with the leakage**NNHELP**☐ I do not know where to seek help**NTHelp**☐ I do not know what type of help is available**NEMB**☐ It is embarrassing to discuss**NDBOT**☐ I didn't want to bother my doctor**NPHYEX**☐ I didn't want a physical exam**NTEST**☐ I didn't want any extensive, painful or invasive tests**NAFR**☐ I was afraid of surgery**NOTH**☐ Other**ALL BUBBLES CODED AS 1**



Draft

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HEALTH HISTORY (Self-Administered)

VISIT

Visit: -3 Screening

14. Did your leakage of urine limit your years of employment or volunteer work?

LIMIT1 ☐ Yes0 ☐ No8 ☐ Don't Know

14a. How old were you when you stopped your employment or volunteer work because of your urine leakage?

years old

AGEST

14b. What was your yearly salary when you stopped working because of your urine leakage?

\$,

dollars

YSAL15. Have you ever been told by a doctor, nurse, or other healthcare provider that you have any of the following? (*Please mark all that apply.*)

- TDROP** ☐ Dropping down of the bladder into the vagina (cystocele)
TBULG ☐ Bulging of the rectum into the vagina (rectocele)
TDRUT ☐ Dropping down of the uterus (uterine prolapse)
THYVD ☐ After a hysterectomy, the top of the vagina is dropping down
TPOP ☐ Pelvic organ prolapse
TNON ☐ None of the above

ALL BUBBLES CODED AS 1 FOR #16



Draft

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ID	ACROS	Month DATE Day Year STFID	

HEALTH HISTORY (Self-Administered)

VISIT

Visit: -3 Screening

16. Has a doctor ever told you that you had, or currently have, any of the following conditions or diseases?

a. A fistula or a hole in your bladder, rectum or near there?

1 ☐ Yes

0 ☐ No

8 ☐ Don't Know

FIST

b. A birth defect leading to urine leakage?

1 ☐ Yes

0 ☐ No

8 ☐ Don't Know

BDEF

c. Urine leakage starting in childhood?

1 ☐ Yes

0 ☐ No

8 ☐ Don't Know

CHUL

d. Interstitial cystitis or very painful bladder?

1 ☐ Yes

0 ☐ No

8 ☐ Don't Know

IC

e. Problems with your spinal cord or back leading to urine leakage?

1 ☐ Yes

0 ☐ No

8 ☐ Don't Know

SPCO

ALL FIELDS START WITH "H6"





Draft

Participant ID #	Acrostic	Date of Visit	Staff ID #
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ID	ACROS	Month DATE Day Year	STFID

HEALTH HISTORY

(Self-Administered)

VISIT

Visit: -3 Screening

16. (Continued)

Has a doctor ever told you that you had, or currently have, any of the following conditions or diseases?

f. Multiple sclerosis?

1 ☐ Yes0 ☐ No8 ☐ Don't Know**MSC**

g. Parkinson's disease?

1 ☐ Yes0 ☐ No8 ☐ Don't Know**PARK**

17. Has a health care provider ever told you that you had, or currently have, hypertension?

1 ☐ Yes0 ☐ No**HYP**

18. Has a health care provider ever told you that you had, or currently have, high cholesterol?

1 ☐ Yes0 ☐ No**HIGHC**

19. Has a health care provider ever told you that you had, or currently have, coronary heart disease?

1 ☐ Yes0 ☐ No**CHD****ALL FIELDS START WITH "H7"**



Draft

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HEALTH UTILITIES INDEX

VISIT

 Visit: ☐ Randomization ☒ 6 months ☒ 12 months ☒ 18 months

Participant Instructions: When answering these questions, please think about your health and your ability to do things on a day-to-day basis, **during the past week**. Please focus your answers on your abilities, disabilities and how you have felt **during the past week**.

You may feel that some of these questions do not apply to you, but it is important that we ask the same questions of everyone.

Please read each question and consider your answers carefully. For each question, please select one answer that best describes your level of ability or disability **during the past week**. Please indicate the selected answer by filling in the circle beside the answer.

1. Which one of the following best describes your ability, **during the past week**, to see well enough to read ordinary newspaper?

- ☒ ☐ Able to see well enough without glasses or contact lenses.
☐ ☐ Able to see well enough with glasses or contact lenses.
☐ ☐ Unable to see well enough even with glasses or contact lenses.
☐ ☐ Unable to see at all.

READM

2. Which one of the following best describes your ability, **during the past week**, to see well enough to recognize a friend on the other side of the street?

- ☒ ☐ Able to see well enough without glasses or contact lenses.
☐ ☐ Able to see well enough with glasses or contact lenses.
☐ ☐ Unable to see well enough even with glasses or contact lenses.
☐ ☐ Unable to see at all.

RCFRI

3. Which one of the following best describes your ability, **during the past week**, to hear what was said in a group conversation with at least three other people?

- ☒ ☐ Able to hear what was said without a hearing aid.
☐ ☐ Able to hear what was said with a hearing aid.
☐ ☐ Unable to hear what was said even with a hearing aid.
☐ ☐ Unable to hear what was said, but did not wear a hearing aid.
☐ ☐ Unable to hear at all.

HEARGR




Draft

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				STFID

HEALTH UTILITIES INDEX

VISIT
Visit: ☐ Randomization ☒ 6 months ☒ 12 months ☒ 18 months

4. Which one of the following best describes your ability, **during the past week**, to hear what was said in a conversation with one other person in a quiet room?

0 ☐ Able to hear what was said without a hearing aid.

1 ☐ Able to hear what was said with a hearing aid.

2 ☐ Unable to hear what was said even with a hearing aid.

HEAR1P

3 ☐ Unable to hear what was said, but did not wear a hearing aid.

4 ☐ Unable to hear at all.

5. Which one of the following best describes your ability, **during the past week**, to be understood when speaking your own language with people who do not know you?

0 ☐ Able to be understood completely.

UNDPDK

1 ☐ Able to be understood partially.

2 ☐ Unable to be understood.

3 ☐ Unable to speak at all.

6. Which one of the following best describes your ability, **during the past week**, to be understood when speaking with people who know you well?

0 ☐ Able to be understood completely.

UNDPYK

1 ☐ Able to be understood partially.

2 ☐ Unable to be understood.

3 ☐ Unable to speak at all.





Draft

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HEALTH UTILITIES INDEX

VISIT

Visit: ☒ Randomization ☐ 6 months ☐ 12 months ☐ 18 months

7. Which one of the following best describes how you have been feeling **during the past week**?
- 0** ☐ Happy and interested in life.
- 1** ☐ Somewhat happy.
- 2** ☐ Somewhat unhappy. **FEELPW**
- 3** ☐ Very unhappy.
- 4** ☐ So unhappy that life was not worthwhile.
8. Which one of the following best describes the pain and discomfort you have experienced **during the past week**?
- 0** ☐ Free of pain and discomfort.
- 1** ☐ Mild to moderate pain or discomfort that prevented no activities. **PAINDI**
- 2** ☐ Moderate pain or discomfort that prevented some activities.
- 3** ☐ Moderate to severe pain or discomfort that prevented some activities.
- 4** ☐ Severe pain or discomfort that prevented most activities.
9. Which one of the following best describes your ability, **during the past week**, to walk?
- Note:** Walking equipment refers to mechanical supports such as braces, a cane, crutches, or a walker.
- 0** ☐ Able to walk around the neighborhood without difficulty, and without walking equipment.
- 1** ☐ Able to walk around the neighborhood with difficulty, but did not require walking equipment or the help of another person.
- 2** ☐ Able to walk around the neighborhood with walking equipment, but without the help of another person. **WALK**
- 3** ☐ Able to walk only short distances with walking equipment, and required a wheelchair to get around the neighborhood.
- 4** ☐ Unable to walk alone, even with walking equipment. Able to walk short distances with the help of another person, and required a wheelchair to get around the neighborhood.
- 5** ☐ Unable to walk at all.





Draft

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HEALTH UTILITIES INDEX

VISIT

Visit: ☒ Randomization ☐ 6 months ☐ 12 months ☐ 18 months

10. Which one of the following best describes your ability, **during the past week**, to use your hands and fingers?

Note: *Special tools refers to hooks for buttoning clothes, gripping devices for opening jars or lifting small items, and other devices to compensate for limitations of hands or fingers.*

0

- ☐ Full use of two hands and ten fingers.

HANFIN

1

- ☐ Limitations in the use of hands or fingers, but did not require special tools or the help of another person.

2

- ☐ Limitations in the use of hands or fingers, independent with use of special tools (did not require the help of another person).

3

- ☐ Limitations in the use of hands or fingers, required the help of another person for some tasks (not independent even with use of special tools).

4

- ☐ Limitations in the use of hands or fingers, required the help of another person for most tasks (not independent even with use of special tools).

5

- ☐ Limitations in the use of hands or fingers, required the help of another person for all tasks (not independent even with use of special tools).

11. Which one of the following best describes your ability, **during the past week**, to remember things?

- 0 ☐ Able to remember most things.

- 1 ☐ Somewhat forgetful.

REM

- 2 ☐ Very forgetful.

- 3 ☐ Unable to remember anything at all.

12. Which one of the following best describes your ability, **during the past week**, to think and solve day to day problems?

- 0 ☐ Able to think clearly and solve day to day problems.

SOLVEP

- 1 ☐ Had a little difficulty when trying to think and solve day to day problems.

- 2 ☐ Had some difficulty when trying to think and solve day to day problems.

- 3 ☐ Had great difficulty when trying to think and solve day to day problems.

- 4 ☐ Unable to think or solve day to day problems.





Draft

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HEALTH UTILITIES INDEX

VISIT

 Visit: ☒ Randomization ☐ 6 months ☐ 12 months ☐ 18 months

13. Which one of the following best describes your ability, **during the past week**, to perform basic activities?
- 0** ☐ Eat, bathe, dress and use the toilet normally. **BASIC**
- 1** ☐ Eat, bathe, dress or use the toilet independently with difficulty.
- 2** ☐ Required mechanical equipment to eat, bathe, dress or use the toilet independently.
- 3** ☐ Required the help of another person to eat, bathe, dress or use the toilet.
14. Which one of the following best describes how you have been feeling **during the past week**?
- 0** ☐ Generally happy and free from worry.
- 1** ☐ Occasionally fretful, angry, irritable, anxious or depressed. **FEEL**
- 2** ☐ Often fretful, angry, irritable, anxious or depressed.
- 3** ☐ Almost always fretful, angry, irritable, anxious or depressed.
- 4** ☐ Extremely fretful, angry, irritable, anxious or depressed, to the point of needing professional help.
15. Which one of the following best describes the pain or discomfort you have experienced **during the past week**?
- 0** ☐ Free of pain and discomfort. **PAIND2**
- 1** ☐ Occasional pain or discomfort. Discomfort relieved by non-prescription drugs or self-control activity without disruption of normal activities.
- 2** ☐ Frequent pain or discomfort. Discomfort relieved by oral medicines with occasional disruption of normal activities.
- 3** ☐ Frequent pain or discomfort; frequent disruption of normal activities. Discomfort required prescription narcotics for relief.
- 4** ☐ Severe pain or discomfort. Pain not relieved by drugs and constantly disrupted normal activities.



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HEIGHT/WEIGHT

-3

Visit: ☐ Screening**VISIT****Instructions:** Please use a black pen.

Standing Height

- Measurement 1 . m **HGT1**
(divide reading in cm. by 100)
- Measurement 2 . m **HGT2**
- The average of Measurement 1 and Measurement 2 = . m **HGTAV**

Weight

- Measurement 1 . **WT1**
kg
- Measurement 2 . **WT2**
kg
- The average of Measurement 1 and Measurement 2 = . kg **WTAV**

BMI

- Calculated BMI =

$$\frac{\text{Weight from \#6 in Kilograms}}{(\text{Height from \#3 in Meters}) \times (\text{Height from \#3 in Meters})} = \text{ABMFI} \quad \text{kg/m}^2$$

- BMI From Chart = **CBMI**
kg/m²

NOTE TO INTERVIEWER: If BMI is < 25 kg/m² or > 50 kg/m², participant is **NOT ELIGIBLE.** → Please fill out the Inclusion/Exclusion form.

ALL FIELDS START WITH "HW"



Draft

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INCONTINENCE IMPACT QUESTIONNAIRE (IIQ) (Self-Administered)

Visit: ☐ ⁻³ Screening ☐ ⁶ months ☐ ¹² months ☐ ¹⁸ months **VISIT**

Instructions: **ALL FIELDS START WITH "I1"** Please use a black pen and fill in bubbles completely.

Some women find that accidental urine loss may affect their activities, relationships, and feelings. The questions below refer to areas in your life which may have been influenced or changed by your problem. For each question, mark the response that best describes how much your activities, relationships, and feelings are being affected by urine leakage. If you don't do the activity, mark "not at all". Please remember to fill in the bubble completely.

How much has urine leakage affected your...	Not at all 0	Slightly 1	Moderately 2	Greatly 3
1. Ability to do household chores (cooking, housecleaning, laundry)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Ability to do usual maintenance or repair work done in home or yard?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Shopping activities?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Hobbies and pastime activities?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Physical recreational activities such as walking, swimming, or other exercise?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Entertainment activities such as going to a movie or concert?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Ability to travel by car or bus for distances less than 20 minutes away from home?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. Ability to travel by car or bus for distances greater than 20 minutes from home?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Going places if you are not sure about available restrooms?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>





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Participant ID #	Acrostic	Date of Visit	Staff ID #
<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>
ID	ACROS	DATE Day Year STFID	

INCONTINENCE IMPACT QUESTIONNAIRE (IIQ) (Self-Administered)

Visit: ☒ Screening ☐ 6 months ☐ 12 months ☐ 18 months **VISIT**

How much has urine leakage affected your...	Not at all 0	Slightly 1	Moderately 2	Greatly 3
10. Going on vacation?	<input type="radio"/> VACA	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. Church or temple attendance?	<input type="radio"/> CHURCH	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. Volunteer activities?	<input type="radio"/> VOL	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. Employment (work) outside the home?	<input type="radio"/> EMP	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. Having friends visit you in your home?	<input type="radio"/> FRI	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. Participating in social activities outside your home?	<input type="radio"/> SOC	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. Relationship with friends?	<input type="radio"/> REL FRI	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. Relationship with family other than husband/companion?	<input type="radio"/> REL FA	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. Ability to have sexual relations?	<input type="radio"/> SEX	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. Way you dress?	<input type="radio"/> DRESS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20. Emotional health?	<input type="radio"/> EMOH	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21. Physical health?	<input type="radio"/> PHYH	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22. Sleep?	<input type="radio"/> SLE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23. Does fear of odor restrict your activities?	<input type="radio"/> FEARO	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24. Does fear of embarrassment restrict your activities?	<input type="radio"/> FEARE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>





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Participant ID #	Acrostic	Date of Visit			Staff ID #
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
ID	ACROS	Month	Day	Year	STFID

INCONTINENCE IMPACT QUESTIONNAIRE (IIQ) (Self-Administered)

Visit: ☐ 3 Screening ☒ 6 6 months ☐ 12 12 months ☒ 18 18 months **VISIT**

Does your problem cause you to experience any of the following feelings?	Not at all 0	Slightly 1	Moderately 2	Greatly 3
25. Nervousness or anxiety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
26. Fear	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
27. Frustration	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
28. Anger	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
29. Depression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
30. Embarrassment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

ALL FIELDS START WITH "I3"





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Participant ID #	Acrostic	Date of Visit			Staff ID #
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ID	ACROS	Month	Day	Year	STFID

RANDOMIZATION/ INCLUSION/EXCLUSION CHECKLIST

Instructions: Please use a black pen and fill in bubbles completely.

1. Inclusion Criteria:

yes=1, no=0

If the answer to any of the following questions is "no" then the participant is **NOT ELIGIBLE** to enroll in the study and you should complete questions 3 and 4.

A. Is the participant aged ≥ 30 years?	AGE	<input type="radio"/> Yes	<input type="radio"/> No
B. Does the participant have a body mass index of 25 to 50 kg/m ² ?	BMI	<input type="radio"/> Yes	<input type="radio"/> No
C. Has the participant experienced urinary incontinence symptoms for ≥ 3 months with ≥ 10 incontinent episodes per week on a 7-day voiding diary?	UIS	<input type="radio"/> Yes	<input type="radio"/> No
D. Is the participant able to complete a behavioral run-in consisting of self-monitoring of food and activity?	RLNIN	<input type="radio"/> Yes	<input type="radio"/> No
E. Does the participant have a primary health care provider?	PCP	<input type="radio"/> Yes	<input type="radio"/> No
F. Can the participant understand and complete self-administered questionnaires?	SELFQ	<input type="radio"/> Yes	<input type="radio"/> No
G. Has the participant agreed not to initiate a new treatment for incontinence or weight reduction, including behavioral, pharmacological or surgical therapies, for the duration of the study?	NONEWT	<input type="radio"/> Yes	<input type="radio"/> No
H. Has the participant signed an informed consent?	INFC	<input type="radio"/> Yes	<input type="radio"/> No
I. Has the participant completed all necessary screening measures and forms?	SCREEN	<input type="radio"/> Yes	<input type="radio"/> No
J. Can the participant walk 2 blocks without stopping and with/without cane or walker?	WALK	<input type="radio"/> Yes	<input type="radio"/> No

2. Exclusion Criteria:

If the answer to any of the following questions is "yes," then the participant is **NOT ELIGIBLE** to enroll in the study and you should complete questions 3 and 4.

A. Is the participant currently using medical therapy for incontinence or weight loss?	TWGTL	<input type="radio"/> Yes	<input type="radio"/> No
B. Is the participant currently engaged in an active weight loss program and/or experienced a 10 lbs or greater weight reduction in the past 3 months?	AWLPM	<input type="radio"/> Yes	<input type="radio"/> No
C. Is the participant pregnant or has she given birth in the past 6 months?	PREG	<input type="radio"/> Yes	<input type="radio"/> No



Draft

Participant ID #	Acrostic	Date of Visit	Staff ID #
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
ID	ACROS	Month DATE Day Year	STFID

RANDOMIZATION/ INCLUSION/EXCLUSION CHECKLIST

2. Exclusion Criteria: (continued)

yes=1, no=0

D. Does the participant have a urinary tract infection or report having ≥ 4 urinary tract infections in the past year?	UTI	<input type="radio"/> Yes	<input type="radio"/> No
E. Does the participant report incontinence of neurologic or functional origin?	INO	<input type="radio"/> Yes	<input type="radio"/> No
F. Has the participant reported any prior anti-incontinence or urethral surgery, pelvic cancer, or pelvic irradiation?	UTSURG	<input type="radio"/> Yes	<input type="radio"/> No
G. Has the participant reported any significant medical conditions of the genitourinary tract?	SMCGT	<input type="radio"/> Yes	<input type="radio"/> No
H. Does the participant have any medical conditions that would affect the safety of the study (type 2 diabetes, uncontrolled HTN, etc)?	MEDCON	<input type="radio"/> Yes	<input type="radio"/> No
I. Has the participant reported any conditions that, in the judgment of the Clinical Center Principal Investigator, render her unlikely to follow the protocol for 18 months, including illness likely to be terminal within 2 years, plans to move, substance abuse or significant psychiatric problems or dementia?	NOPROT	<input type="radio"/> Yes	<input type="radio"/> No
J. Is the participant participating in another research study that involves investigational drugs or that can potentially confound the results of PRIDE?	OSTUDY	<input type="radio"/> Yes	<input type="radio"/> No
K. Is the participant institutionalized?	INST	<input type="radio"/> Yes	<input type="radio"/> No

3. Is the participant eligible to be randomized? (please select only ONE bubble)

- ☒ Yes, meets all inclusion/exclusion criteria **ELIG**
☐ No, does not meet all inclusion/exclusion criteria

4. Was the participant randomized?

- ☒ Yes \longrightarrow / / \longrightarrow
- Month Day Year

- ☐ No, not eligible
☐ No, participant refused

RAND

Randomization #
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

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Site	Group	Session Number	Session Date			Data Entry Staff ID #
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/>	
	COHORT		Month	Day	Year	

SITEID

SESS

DATE

STFID

INTERVENTION RECORD

ID #	Acrostic	Attended Group	Weight at Visit (lb)	Weekly Exer Min	Diary Rating
		1 0			0 1 2
ID	ACROS	ATT	WT	MIN	DIA
<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No	<input type="text"/>	<input type="text"/>	<input type="radio"/> ND <input type="radio"/> Fair <input type="radio"/> Good
<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No	<input type="text"/>	<input type="text"/>	<input type="radio"/> ND <input type="radio"/> Fair <input type="radio"/> Good
<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No	<input type="text"/>	<input type="text"/>	<input type="radio"/> ND <input type="radio"/> Fair <input type="radio"/> Good
<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No	<input type="text"/>	<input type="text"/>	<input type="radio"/> ND <input type="radio"/> Fair <input type="radio"/> Good
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<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No	<input type="text"/>	<input type="text"/>	<input type="radio"/> ND <input type="radio"/> Fair <input type="radio"/> Good
<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No	<input type="text"/>	<input type="text"/>	<input type="radio"/> ND <input type="radio"/> Fair <input type="radio"/> Good
<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No	<input type="text"/>	<input type="text"/>	<input type="radio"/> ND <input type="radio"/> Fair <input type="radio"/> Good
<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No	<input type="text"/>	<input type="text"/>	<input type="radio"/> ND <input type="radio"/> Fair <input type="radio"/> Good
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<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No	<input type="text"/>	<input type="text"/>	<input type="radio"/> ND <input type="radio"/> Fair <input type="radio"/> Good

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Site	Group	Session Number	Session Date			Data Entry Staff ID #
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	COHORT		Month	Day	Year	

PRIDE

SITEID

SESS

DATE

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MAINTENANCE RECORD

ID # ID	Acroscopic ACROS	Attended Group ATT <input type="radio"/> Yes <input type="radio"/> No	Weight at Visit (lb) WT	Week Before Session		Week of Session	
				Weekly Exer Min MIN	Diary Rating DIA	Weekly Exer Min MIN2	Diary Rating DIA2
<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No	<input type="text"/>	<input type="text"/>	<input type="radio"/> ND <input type="radio"/> Fair <input type="radio"/> Good	<input type="text"/>	<input type="radio"/> ND <input type="radio"/> Fair <input type="radio"/> Good
<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No	<input type="text"/>	<input type="text"/>	<input type="radio"/> ND <input type="radio"/> Fair <input type="radio"/> Good	<input type="text"/>	<input type="radio"/> ND <input type="radio"/> Fair <input type="radio"/> Good
<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No	<input type="text"/>	<input type="text"/>	<input type="radio"/> ND <input type="radio"/> Fair <input type="radio"/> Good	<input type="text"/>	<input type="radio"/> ND <input type="radio"/> Fair <input type="radio"/> Good
<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No	<input type="text"/>	<input type="text"/>	<input type="radio"/> ND <input type="radio"/> Fair <input type="radio"/> Good	<input type="text"/>	<input type="radio"/> ND <input type="radio"/> Fair <input type="radio"/> Good
<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No	<input type="text"/>	<input type="text"/>	<input type="radio"/> ND <input type="radio"/> Fair <input type="radio"/> Good	<input type="text"/>	<input type="radio"/> ND <input type="radio"/> Fair <input type="radio"/> Good
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<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No	<input type="text"/>	<input type="text"/>	<input type="radio"/> ND <input type="radio"/> Fair <input type="radio"/> Good	<input type="text"/>	<input type="radio"/> ND <input type="radio"/> Fair <input type="radio"/> Good
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<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No	<input type="text"/>	<input type="text"/>	<input type="radio"/> ND <input type="radio"/> Fair <input type="radio"/> Good	<input type="text"/>	<input type="radio"/> ND <input type="radio"/> Fair <input type="radio"/> Good
<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No	<input type="text"/>	<input type="text"/>	<input type="radio"/> ND <input type="radio"/> Fair <input type="radio"/> Good	<input type="text"/>	<input type="radio"/> ND <input type="radio"/> Fair <input type="radio"/> Good
<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No	<input type="text"/>	<input type="text"/>	<input type="radio"/> ND <input type="radio"/> Fair <input type="radio"/> Good	<input type="text"/>	<input type="radio"/> ND <input type="radio"/> Fair <input type="radio"/> Good
<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No	<input type="text"/>	<input type="text"/>	<input type="radio"/> ND <input type="radio"/> Fair <input type="radio"/> Good	<input type="text"/>	<input type="radio"/> ND <input type="radio"/> Fair <input type="radio"/> Good
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<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No	<input type="text"/>	<input type="text"/>	<input type="radio"/> ND <input type="radio"/> Fair <input type="radio"/> Good	<input type="text"/>	<input type="radio"/> ND <input type="radio"/> Fair <input type="radio"/> Good
<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No	<input type="text"/>	<input type="text"/>	<input type="radio"/> ND <input type="radio"/> Fair <input type="radio"/> Good	<input type="text"/>	<input type="radio"/> ND <input type="radio"/> Fair <input type="radio"/> Good

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Participant ID #	Acrostic	Date of Visit			Staff ID #
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ID	ACROS	Month	Day	Year	STFID

DATE MEDICATIONS FORM

VISIT Visit: ☒ **-3** ☐ Screening ☐ 6 months ☐ 12 months ☐ 18 months

Instructions: Please use a black pen and use ALL CAPITAL LETTERS to print words.

Record any prescription or over the counter medications the participant is taking.

Please record trade name OR generic name.

1. Trade name	<input type="text"/>	TRM1
OR		GEM1
Generic name	<input type="text"/>	
2. Trade name	<input type="text"/>	TRM2
OR		GEM2
Generic name	<input type="text"/>	
3. Trade name	<input type="text"/>	TRM3
OR		GEM3
Generic name	<input type="text"/>	
4. Trade name	<input type="text"/>	TRM4
OR		GEM4
Generic name	<input type="text"/>	
5. Trade name	<input type="text"/>	TRM5
OR		GEM5
Generic name	<input type="text"/>	
6. Trade name	<input type="text"/>	TRM6
OR		GEM6
Generic name	<input type="text"/>	
7. Trade name	<input type="text"/>	TRM7
OR		GEM7
Generic name	<input type="text"/>	





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Participant ID #	Acrostic	Date of Visit	Staff ID #
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ID	ACROS	DATE <small>Month Day Year</small>	STFID

PRIDE MEDICATIONS FORM

VISIT
Visit: ☐ -3 ☐ 6 ☐ 12 ☐ 18
Screening months months months months

Record any prescription or over the counter medications the participant is taking.
Please record trade name OR generic name.

8. Trade name	<div style="border: 1px solid black; width: 200px; height: 20px;"></div>	TRM8
OR		GEM8
Generic name	<div style="border: 1px solid black; width: 200px; height: 20px;"></div>	
9. Trade name	<div style="border: 1px solid black; width: 200px; height: 20px;"></div>	TRM9
OR		GEM9
Generic name	<div style="border: 1px solid black; width: 200px; height: 20px;"></div>	
10. Trade name	<div style="border: 1px solid black; width: 200px; height: 20px;"></div>	TRM10
OR		GEM10
Generic name	<div style="border: 1px solid black; width: 200px; height: 20px;"></div>	
11. Trade name	<div style="border: 1px solid black; width: 200px; height: 20px;"></div>	TRM11
OR		GEM11
Generic name	<div style="border: 1px solid black; width: 200px; height: 20px;"></div>	
12. Trade name	<div style="border: 1px solid black; width: 200px; height: 20px;"></div>	TRM12
OR		GEM12
Generic name	<div style="border: 1px solid black; width: 200px; height: 20px;"></div>	
13. Trade name	<div style="border: 1px solid black; width: 200px; height: 20px;"></div>	TRM13
OR		GEM13
Generic name	<div style="border: 1px solid black; width: 200px; height: 20px;"></div>	
14. Trade name	<div style="border: 1px solid black; width: 200px; height: 20px;"></div>	TRM14
OR		GEM14
Generic name	<div style="border: 1px solid black; width: 200px; height: 20px;"></div>	





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Participant ID #	Acrostic	Date of Visit	Staff ID #
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MOTIVATION MAINTENANCE PROGRAM EXIT QUESTIONNAIRE

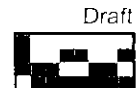
Instructions: Please use a black pen and fill in bubbles completely.

The purpose of these questions is to help us design a better program for the future. So, please be as honest and forthright as possible in your evaluation of your PRIDE program experience. We appreciate your feedback and efforts to help us refine the program.

Section 1

	Please rate your experience using the 5 point scale:					
	1 Not at all	2	3 Somewhat	4	5 Extremely	N/A*
1. How useful were the maintenance sessions between months 6 and 18 in helping you lose and/or maintain your weight?	1 <input type="radio"/> USEF	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>	5 <input type="radio"/>	0 <input type="radio"/>
2. How much did you enjoy coming to the maintenance sessions?	<input type="radio"/> ENJOY	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Would you recommend the maintenance program to a friend who is working on weight loss?	<input type="radio"/> RECOM	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. How helpful or valuable were the weigh-ins?	<input type="radio"/> HWEI	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. How helpful or valuable was the review of diaries by the therapists?	<input type="radio"/> HREV	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. How helpful or valuable was it to receive the weight and exercise graphs distributed at some sessions by your group leader?	<input type="radio"/> HGRA	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. How helpful or valuable was it to receive the printed materials (i.e., handouts)?	<input type="radio"/> HAND	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

*N/A= attended too few sessions to rate





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Participant ID #	Acrostic	Date of Visit			Staff ID #
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ID	ACROS	Month	Day	Year	STFID

MOTIVATION MAINTENANCE PROGRAM EXIT QUESTIONNAIRE

Section II

How **helpful** or **valuable** were the following specific activities in your weight loss and maintenance efforts?

Please rate your experience using the 5 point scale:

	1	2	3	4	5	N/A*
	Not at all helpful		Somewhat helpful		Extremely helpful	
1. Using a scrapbook or journal to chronicle your weight loss journey	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		SCRAP				
2. Reviewing the individual video you made at the start of the study	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		RVID				
3. Wearing a backpack to simulate the feeling of an extra 10 lbs.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		WBACK				
4. Becoming aware of and changing "Yes, But" statements	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		YESBUT				
5. Noting the values in your life and how they relate to your weight and health priorities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		VALUEL				
6. Focusing on developing hobbies/pleasant activities as a way of taking care of yourself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		HOBB				
7. Changing your commitment language	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		COMML				
8. Envisioning the future by writing about how you would like it to unfold	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		WRITE				
9. Making a group video	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		GVIDEO				
10. Establishing a "culture of support"	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		CULTSU				

*N/A= attended too few sessions to rate





Draft

PRIDE

Participant ID #	Acrostic	Date of Visit		Staff ID #
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
ID	ACROS	Month	DATE	Year
				STFID

MOTIVATION QUESTIONNAIRE (Baseline)

(Self-Administered)

VISITVisit: ☐ Randomization**0**

Instructions: Please use a black pen and fill in all bubbles completely.

- A. The following questions relate to the reasons why you would engage in behaviors to control your weight. Different people have different reasons for doing that, and we want to know how true each of the following reasons is for you. All 12 responses are to the same.

The reason I would try to control my weight is:		Please indicate the extent to which each reason is true for you, using the following 7-point scale:						
		1	2	3	4	5	6	7
		Not at all	somewhat true				very true	
QA1	1. Because I feel that I want to take responsibility for my own health.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
QA2	2. Because I would feel guilty or ashamed of myself if I did not try to control my weight.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
QA3	3. Because I personally believe it is the best thing for my health.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
QA4	4. Because others would be upset with me if I did not.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
QA5	5. Because I have carefully thought about it and believe it is very important for many aspects of my life.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
QA6	6. Because I would feel bad about myself if I did not try to control my weight.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
QA7	7. Because it is an important choice I really want to make.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
QA8	8. Because I feel pressure from others to do so.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
QA9	9. Because it is consistent with my life goals.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Q10	10. Because I want others to approve of me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Q11	11. Because it is very important for being as healthy as possible.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Q12	12. Because I want others to see I can do it.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>





Draft

Participant ID #	Acrostic	Date of Visit		Staff ID #
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
ID	ACROS	Month	DATE	Year
STFID				

MOTIVATION QUESTIONNAIRE (Baseline) (Self-Administered)

VISITVisit: ☐ Randomization **0**

B. These statements relate to exercise. Please indicate how much you agree with each the statement by filling in the bubble:

CODED 1-5 IN ORDER

		Strongly disagree	Somewhat disagree	Undecided	Somewhat agree	Strongly agree
QB1	1. I consider myself an exerciser.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
QB2	2. When I describe myself to others, I usually include my involvement in exercise.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
QB3	3. Physical exercise is a central factor to my self-concept.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
QB4	4. Others see me as someone who exercises regularly.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

C. These statements relate to low-calorie diets. Please indicate how much you agree with each statement by filling in the bubble:

CODED 1-5 IN ORDER

		Strongly disagree	Somewhat disagree	Undecided	Somewhat agree	Strongly agree
QC1	1. I see myself as someone who regularly eats a low calorie diet.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
QC2	2. When I describe myself to others, I usually include my low calorie eating.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
QC3	3. Eating a low calorie diet is a central factor to my self-concept.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
QC4	4. Others see me as someone who eats a low calorie diet.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

D. These statements relate to weight control. Please indicate how much you agree with each statement by filling in the bubble:

CODED 1-5 IN ORDER

		Strongly disagree	Somewhat disagree	Undecided	Somewhat agree	Strongly agree
QD1	1. I consider myself as someone who is successful at controlling my weight.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
QD2	2. When I describe myself to others, I usually include my involvement in weight control.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
QD3	3. Controlling my weight is a central factor to my self-concept.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
QD4	4. Others see me as someone who tries to control my weight.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



Draft

Participant ID #	Acrostic	Date of Visit	Staff ID #
<div> <div></div> <div></div> <div></div> <div></div> <div></div> </div> <div>ID</div>	<div> <div></div> <div></div> <div></div> <div></div> <div></div> </div> <div>ACROS</div>	<div> <div></div> <div></div> </div> <div>Month</div> <div> <div></div> <div></div> </div> <div>DATE</div> <div> <div></div> <div></div> <div></div> <div></div> </div> <div>Year</div>	<div> <div></div> <div></div> <div></div> </div> <div>STFID</div>

MOTIVATION QUESTIONNAIRE (Baseline)

(Self-Administered)

VISIT

Visit: ☐ Randomization **0**

Q

E. Please answer the following questions by filling in the bubbles **CODED 1-5 IN ORDER**

		Strongly disagree	Somewhat disagree	Undecided	Somewhat agree	Strongly agree
QE1	1. There are pleasurable activities other than eating which I enjoy doing during my leisure time.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
QE2	2. I make time for myself.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
QE3	3. I take time to be "good" to myself.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
QE4	4. I have a lot of worthwhile qualities.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
QE5	5. By the time I am done taking care of my family, I have no time left for myself.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
QE6	6. I withhold certain rewards for myself until I accomplish my goals.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
QE7	7. I find eating to be a very pleasurable activity.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

F. Please answer the following question by filling in the bubble. **CODING 1-5 IN ORDER**

		No effort	Slight effort	Moderate effort	Quite a bit of effort	Extreme effort
QF1	1. At present, how much effort are you currently putting into trying to control your weight?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

G. Please answer the following questions by filling in the bubble.

		Not at all satisfied	Slightly satisfied	Moderately satisfied	Quite a bit satisfied	Extremely satisfied
QG1	1. How satisfied are you with your current weight?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
QG2	2. How satisfied are you with your current physical activity habits?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
QG3	3. How satisfied are you with your current eating habits?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>





Draft

Participant ID #	Acrostic	Date of Visit	Staff ID #
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ID	ACROS	Month DATE Year	STFID

MOTIVATION QUESTIONNAIRE (Baseline) (Self-Administered)

VISIT

Visit:

☐ Randomization **0**

H. During the past month, how often did you weigh yourself? (Check the answer that best applies)

0	<input type="radio"/>	Several times a day
1	<input type="radio"/>	One time each day
2	<input type="radio"/>	Several times a week
3	<input type="radio"/>	One time a week
4	<input type="radio"/>	Less than once a week
5	<input type="radio"/>	Less than once a month
6	<input type="radio"/>	Never weighed myself

QH

Draft

Participant ID #	Acrostic	Date of Visit			Staff ID #
<div> <div></div> <div></div> <div></div> <div></div> <div></div> </div> <div>ID</div>	<div> <div></div> <div></div> <div></div> <div></div> <div></div> </div> <div>ACROS</div>	<div> <div></div> <div></div> </div> <div>Month</div>	<div> <div></div> <div></div> </div> <div>DATE</div>	<div> <div></div> <div></div> <div></div> <div></div> </div> <div>Year</div>	<div> <div></div> <div></div> <div></div> <div></div> </div> <div>STFID</div>

MOTIVATION QUESTIONNAIRE (Follow-up)

(Self-Administered)

VISIT Visit: ☒ 6 months ☐ 12 months ☐ 18 months

Instructions: Please use a black pen and fill in all bubbles completely.

- A.** The following questions relate to the reasons why you would engage in behaviors to control your weight. Different people have different reasons for doing that, and we want to know how true each of the following reasons is for you. All 13 responses are to the same question.

[illegible]



Draft

Participant ID #	Acrostic	Date of Visit		Staff ID #
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
ID	ACROS	Month	DATE Day	Year
				STFID

MOTIVATION QUESTIONNAIRE (Follow-up) (Self-Administered)

VISITVisit: ~~6~~ 6 months ~~12~~ 12 months ~~18~~ 18 months

B. These statements relate to exercise. Please indicate how much you agree with each statement by filling in the bubble:

CODED 1-5 IN ORDER

		Strongly disagree	Somewhat disagree	Undecided	Somewhat agree	Strongly agree
QB1	1. I consider myself an exerciser.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
QB2	2. When I describe myself to others, I usually include my involvement in exercise.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
QB3	3. Physical exercise is a central factor to my self-concept.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
QB4	4. Others see me as someone who exercises regularly.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

C. These statements relate to low-calorie diets. Please indicate how much you agree with each statement by filling in the bubble:

CODED 1-5 IN ORDER

		Strongly disagree	Somewhat disagree	Undecided	Somewhat agree	Strongly agree
QC1	1. I see myself as someone who regularly eats a low calorie diet.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
QC2	2. When I describe myself to others, I usually include my low calorie eating.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
QC3	3. Eating a low calorie diet is a central factor to my self-concept.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
QC4	4. Others see me as someone who eats a low calorie diet.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

D. These statements relate to weight control. Please indicate how much you agree with each statement by filling in the bubble:

CODED 1-5 IN ORDER

		Strongly disagree	Somewhat disagree	Undecided	Somewhat agree	Strongly agree
QD1	1. I consider myself as someone who is successful at controlling my weight.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
QD2	2. When I describe myself to others, I usually include my involvement in weight control.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
QD3	3. Controlling my weight is a central factor to my self-concept.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
QD4	4. Others see me as someone who tries to control my weight.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>





Draft

Participant ID #	Acrostic	Date of Visit			Staff ID #
<div> <div></div> <div></div> <div></div> <div></div> <div></div> </div> ID	<div> <div></div> <div></div> <div></div> <div></div> <div></div> </div> ACROS	<div> <div></div> <div></div> </div> Month	<div> <div></div> <div></div> </div> DATE	<div> <div></div> <div></div> <div></div> <div></div> </div> Year	<div> <div></div> <div></div> <div></div> </div> STFID

MOTIVATION QUESTIONNAIRE (Follow-up)

(Self-Administered)

VISIT

Visit: ☒ ⁶6 months ☐ ¹²12 months ☐ ¹⁸18 months

E. Please answer the following questions by filling in the bubbles 1-5 IN ORDER

		Strongly disagree	Somewhat disagree	Undecided	Somewhat agree	Strongly agree
QE1	1. There are pleasurable activities other than eating which I enjoy doing during my leisure time.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
QE2	2. I make time for myself.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
QE3	3. I take time to be "good" to myself.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
QE4	4. I have a lot of worthwhile qualities.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
QE5	5. By the time I am done taking care of my family, I have no time left for myself.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
QE6	6. I withhold certain rewards for myself until I accomplish my goals.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
QE7	7. I find eating to be a very pleasurable activity.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

F. Please answer the following question by filling in the bubble. **CODED 1-5 IN ORDER**

		No effort	Slight effort	Moderate effort	Quite a bit of effort	Extreme effort
QF1	1. At present, how much effort are you currently putting into trying to control your weight?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

G. Please answer the following questions by filling in the bubble. CODED 1-5 IN ORDER

		Not at all satisfied	Slightly satisfied	Moderately satisfied	Quite a bit satisfied	Extremely satisfied
QG1	1. How satisfied are you with your current weight?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
QG2	2. How satisfied are you with your current physical activity habits?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
QG3	3. How satisfied are you with your current eating habits?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>





Draft

Participant ID #	Acrostic	Date of Visit			Staff ID #
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ID	ACROS	Month	Day	Year	STFID

MOTIVATION QUESTIONNAIRE (Follow-up) (Self-Administered)

VISIT Visit: ☒ 6 months ☐ 12 months ☐ 18 months

H. During the past month, how often did you weigh yourself? (Check the answer that best applies)

0	<input type="radio"/>	Several times a day
1	<input type="radio"/>	One time each day
2	<input type="radio"/>	Several times a week
3	<input type="radio"/>	One time a week
4	<input type="radio"/>	Less than once a week
5	<input type="radio"/>	Less than once a month
6	<input type="radio"/>	Never weighed myself

QH

I. Please answer the following question by filling in the bubble.

CODED 1-7 IN ORDER

QI1	The way I keep trying to maintain my weight loss is by:	Very true of me						
		1	2	3	4	5	6	7
	1. Thinking about how far I have come and the progress I have made.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

J. Please answer the following question by filling in the bubble.

CODED 1-7 IN ORDER

QJ1	Please indicate how confident you are that you will be able to do the following activities:	Very confident						
		1	2	3	4	5	6	7
	1. Identify a variety of different exercises to keep my exercise program interesting.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
QJ2	2. Identify foods that have low energy density.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
QJ3	3. Modify recipes so that they are low calorie and low fat but still flavorful.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
QJ4	4. Develop a specific plan to overcome problems related to my weight.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>





Draft

PRIDE

Participant ID #	Acrostic	Date of Visit			Staff ID #					
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ID	ACROS	Month		Day		DATE	Year			STFID

NON-INSTRUMENTED UROFLOWMETRY

VISIT

1

7

(NIF)

Visit: ☐ UDS Baseline ☐ UDS 6 months

Instructions: Please use a black pen and fill in bubble completely.

- Maximum Flow Rate: ml/sec **MAX**
- Mean Flow Rate: ml/sec **MEAN**
- Classify the flow pattern of the urine stream:
0 ☐ Normal (continuous, smooth, arc-shaped signal with high amplitude) **FLOWP**
1 ☐ Abnormal
- Time to maximum flow: sec **TIMAX**
- Voided volume: ml **VOIDV**
- Measured post void residual: ml **SPVR**
- For PVR > 150 cc, measured post void residual # 2 (after CMG) ml
SPVR2

ALL FIELDS START WITH "NI"





Draft

Participant ID #	Acrostic	Date of Visit		Staff ID #
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> ID	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> ACROS	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month DATE Year	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> STFID	

PAD TEST**VISIT**Visit: **0** ☐ RV ☐ 6 months ☒ 12 months ☐ 18 months**Instructions:** Please use a black pen.

1. Date Pad Test Kit Distributed:

 / /
Month Day Year
DDATE

2. Number of pads in the kit:

pads

NPADS**SEE NEXT PAGE FOR 4 AND 6 CODING**

PRE-WEIGHTS		POST-WEIGHTS	
3. DATE PRE-WEIGHTS RECORDED	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year	5. DATE POST-WEIGHTS RECORDED	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year
4. PAD #	PRE-WEIGHT	6. POST-WEIGHT	CONTAMINATION CODE *
A.	<input type="text"/> <input type="text"/> grams	<input type="text"/> <input type="text"/> grams	<input type="text"/> <input type="text"/>
B.	<input type="text"/> <input type="text"/> grams	<input type="text"/> <input type="text"/> grams	<input type="text"/> <input type="text"/>
C.	<input type="text"/> <input type="text"/> grams	<input type="text"/> <input type="text"/> grams	<input type="text"/> <input type="text"/>
D.	<input type="text"/> <input type="text"/> grams	<input type="text"/> <input type="text"/> grams	<input type="text"/> <input type="text"/>
E.	<input type="text"/> <input type="text"/> grams	<input type="text"/> <input type="text"/> grams	<input type="text"/> <input type="text"/>
F.	<input type="text"/> <input type="text"/> grams	<input type="text"/> <input type="text"/> grams	<input type="text"/> <input type="text"/>
G.	<input type="text"/> <input type="text"/> grams	<input type="text"/> <input type="text"/> grams	<input type="text"/> <input type="text"/>
H.	<input type="text"/> <input type="text"/> grams	<input type="text"/> <input type="text"/> grams	<input type="text"/> <input type="text"/>
I.	<input type="text"/> <input type="text"/> grams	<input type="text"/> <input type="text"/> grams	<input type="text"/> <input type="text"/>
J.	<input type="text"/> <input type="text"/> grams	<input type="text"/> <input type="text"/> grams	<input type="text"/> <input type="text"/>

* See contamination codes in Appendix

7. Date Pad Test Kit Returned:

 / /
Month Day Year
RDATE

Draft

CODING FOR #4 AND #6.

**PAD # STARTS "PTPNUM" FOLLOWED BY THE LETTER
(EG. PAD # FOR A IS "PTNUMA")**

PREWEIGHT IS "PTEW" FOLLOWED BY THE LETTER.

POSTWEIGHT IS "PTOW" FOLLOWED BY THE LETTER.

CONTAMINATION CODE IS "PTCC" FOLLWED BY THE LETTER.

	PAD #	PRE-WEIGHT	POST-WEIGHT	CONTAMINATION CODE *
A.	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> grams	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> grams	<input type="text"/> <input type="text"/>

Draft



Draft

Participant ID #	Acrostic	Date of Visit		Staff ID #
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
ID	ACROS	Month	Day	Year

PAFFENBARGER QUESTIONNAIRE (Self-Administered)

VISIT
 Visit: ³ ☐ Screening ⁶ ☐ 6 months ¹² ☐ 12 months ¹⁸ ☐ 18 months

Instructions: Please use a black pen and fill in bubbles completely. Use ALL CAPITAL LETTERS to print words.

1. Was there anything about the past week that made exercising especially different for you in terms of illness, injury or vacation?

¹ ☐ Yes —→ If yes, please answer the following questions referring to a previous "usual week" **DIFF**

⁰ ☐ No —→ If no, please answer the following questions about last week

2. First, we are interested in the number of flights of stairs you climbed on average **EACH DAY** in this past week. We only want to know the number of flights you climbed going UP- not down. One flight = 10 steps, if you know the number of steps.

 flights per day (not steps) **FPD**

3. Next, we want to know how many city blocks or their equivalent you walked on average **EACH DAY** in this past week. We are only interested in walking done outdoors and walking done indoors for the sole purpose of exercise. We do not want walking done around the house or at work.

Consider that 12 city blocks = 1 mile.

 blocks per day **BPD**

4. Were there any sports, fitness, or recreational activities in which you participated in **during the past week**? We are interested only in the times that you were physically active. (Note: all walking should be included in Question 3 only)

Sport, Fitness, or Recreation	Times per Week	Average Time per Episode
SPA	SPAT	SPAA Minutes
SPB	SPBT	SPBA Minutes
SPC	SPCT	SPCA Minutes
SPD	SPDT	SPDA Minutes

Additional activities should be recorded on a separate sheet.



Draft

Participant ID #	Acrostic	Date of Visit			Staff ID #
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
ID	ACROS	Month	Day	Year	STFID

PAFFENBARGER QUESTIONNAIRE (Self-Administered)

VISIT

Visit: **-3** ☐ Screening ☒ **6** months ☒ **12** months ☒ **18** months

Instructions: Please use a black pen and fill in bubbles completely. Use ALL CAPITAL LETTERS to print words.

5. At least once per week, do you engage in regular activity like brisk walking, jogging, bicycling, etc. long enough to work up a sweat, get your heart thumping, or get out of breath?

REGACT

1

☐ Yes

0

☐ No

times per week

REGATW

6. On average, how many hours per week do you spend watching TV/Cable/VCR/DVD?

0

☐ 0 to 1 hours/week

1

☐ 2 to 5 hours/week

2

☐ 6 to 10 hours/week

3

☐ 11 to 20 hours/week

4

☐ 21 to 40 hours/week

5

☐ 41 to 60 hours/week

6

☐ 61 or more hours/week

TVDVD

7. Excluding time spent watching TV/Cable/VCR/DVD, how many hours per week do you spend sitting (e.g., working at a desk, relaxing on the couch, etc)?

0

☐ 0 to 1 hours/week

1

☐ 2 to 5 hours/week

2

☐ 6 to 10 hours/week

3

☐ 11 to 20 hours/week

4

☐ 21 to 40 hours/week

5

☐ 41 to 60 hours/week

6

☐ 61 or more hours/week

SIT

ALL FIELDS START WITH "P2"



Draft

Participant ID #	Acrostic	Date of Visit		Staff ID #
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
ID	ACROS	Month	Day	STFID

PELVIC MUSCLE QUESTIONNAIRE (Self-Administered)

VISIT Visit: ☐ 6 months ☐ 12 months ☐ 18 months

Instructions: Please use a black pen and fill in all bubbles completely.

1. How helpful do you find the "Staying Dry: A Practical Guide to Bladder Control" booklet in providing information about bladder control?

- 0 ☐ Didn't receive the booklet **► You have completed this questionnaire.**
 1 ☐ Haven't read the booklet **HELP**
 2 ☐ Not at all helpful
 3 ☐ Moderately helpful
 4 ☐ Very helpful

2. For how many months, in the past 6 months, did you do the pelvic floor muscle exercises described in the "Staying Dry: A Practical Guide to Bladder Control" booklet?

- 0 ☐ Never did the exercises
 1 ☐ Less than one month **FLEXE**
 2 ☐ One to two months
 3 ☐ Three or more months

3. During the past month, how often have you used the exercises or techniques described in the "Staying Dry: A Practical Guide to Bladder Control" booklet?

	0 Never	1 Monthly (once or more each month)	2 Weekly (once or more each week)	3 Daily (once or more each day)
a. Pelvic floor muscle exercises PELVF	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Using urge suppression to control urge incontinence URGES	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Squeezing my pelvic floor muscles to control stress incontinence SQUEEZE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>





Draft

Participant ID #	Acrostic	Date of Visit			Staff ID #
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>		
ID	ACROS	Month	DATE	Year	STFID

PELVIC MUSCLE QUESTIONNAIRE

(Self-Administered)

VISIT

6

12

18

Visit: ☐ 6 months ☐ 12 months ☐ 18 months

4. What is the most difficult part of the program described in "Staying Dry: A Practical Guide to Bladder Control"? (Please mark all that apply.)

☐ I haven't used the booklet

P4BOOK

☐ No difficulty

P4NODIFF

☐ I was unsure if I was doing the exercises correctly

P4UNSURE

☐ Remembering to do my pelvic floor muscle exercises regularly

P4REMEN

☐ Finding time to do my pelvic floor muscle exercises

P4FTIME

☐ Controlling my urge to rush to the toilet

P4CONT

☐ Squeezing my pelvic floor muscles to prevent stress urine leakages

P4SQUEEZ

☐ Other

P4OTHER

4a. If other, please specify:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	SPEC1	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	SPEC2	<input type="text"/>

ALL BUBBLES

CODED AS 0





Draft

PRIDE

Participant ID #	Acrostic	Date of Visit	Staff ID #
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
ID	ACROS	Month DATE Year	STFID

PELVIC ORGAN PROLAPSE QUANTIFICATION (POP-Q)

VISIT Visit: ☐ UDS Baseline ☒ UDS 6 months

Instructions: Please use a black pen and fill in bubbles completely.

	POINT	[DESCRIPTION]	RECORD VALUE	RANGE	NA
1.	Aa	anterior wall 3 cm from external urethral meatus	1 <input type="radio"/> + <input type="text"/> <input type="text"/> . <input type="text"/> 2 <input type="radio"/> - <input type="text"/> <input type="text"/> . <input type="text"/>	-3 to +3	<input type="radio"/> 1
2.	Ba	most dependent part of anterior wall	1 <input type="radio"/> + <input type="text"/> <input type="text"/> . <input type="text"/> 2 <input type="radio"/> - <input type="text"/> <input type="text"/> . <input type="text"/>	-3 to +TVL	<input type="radio"/> 1
3.	C	cervix or vaginal cuff	1 <input type="radio"/> + <input type="text"/> <input type="text"/> . <input type="text"/> 2 <input type="radio"/> - <input type="text"/> <input type="text"/> . <input type="text"/>	± TVL	<input type="radio"/> 1
4.	D	posterior fornix (if no prior total hyst)	1 <input type="radio"/> + <input type="text"/> <input type="text"/> . <input type="text"/> 2 <input type="radio"/> - <input type="text"/> <input type="text"/> . <input type="text"/>	± TVL	<input type="radio"/> 1
5.	Ap	posterior wall 3 cm from hymen	1 <input type="radio"/> + <input type="text"/> <input type="text"/> . <input type="text"/> 2 <input type="radio"/> - <input type="text"/> <input type="text"/> . <input type="text"/>	-3 to +3	<input type="radio"/> 1
6.	Bp	most dependent part of posterior wall	1 <input type="radio"/> + <input type="text"/> <input type="text"/> . <input type="text"/> 2 <input type="radio"/> - <input type="text"/> <input type="text"/> . <input type="text"/>	-3 to +TVL	<input type="radio"/> 1
7.	GH	genital hiatus (mid urethral meatus to vaginal introitus posterior Fourchette)	<input type="text"/> <input type="text"/> . <input type="text"/>	no limit	<input type="radio"/> 1
8.	PB	perineal body (vaginal introitus posterior Fourchette to mid-anal opening)	<input type="text"/> <input type="text"/> . <input type="text"/>	no limit	<input type="radio"/> 1
9.	TVL	Total Vaginal Length	<input type="text"/> <input type="text"/> . <input type="text"/>	no limit	<input type="radio"/> 1

*10. Indicate the Stage of the prolapse: ☐ Stage 0 or I [2, 3, 6: all ≤ -2]

STAGE ☒ Stage II or higher [2, 3, 6: any ≥ -1]

1-9 naming: PQ + point text +:

PN for +/-

V for value

N for NA

for example:

#1 pos neg: PQAAPN

#1 value: PQA AV

#1 NA : PQAAN





Draft

PRIDE

Participant ID #	Acrostic	Date of Visit	Staff ID #
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
ID	ACROS	Month DATE Day Year	STFID

PUBOCOCCYGEUS CONTRACTION ASSESSMENT

Visit: ¹ ☐ UDS Baseline ☐ ⁷ UDS 6 months VISIT

Instructions: Please use a black pen and fill in bubbles completely.

PARAMETER	RATING DESCRIPTION
1. Pressure	<p>1 <input type="radio"/> No response; cannot perceive pressure on finger surface</p> <p>2 <input type="radio"/> Weak squeeze; felt as a flick at various points along finger surface; not all the way around</p> <p>3 <input type="radio"/> Moderate squeeze; felt all the way around finger surface</p> <p>4 <input type="radio"/> Strong squeeze</p> <p>PRESS</p>
2. Duration	<p><input type="text"/> <input type="text"/> seconds (maximum of 10 seconds)</p> <p>DUR</p>
3. Displacement of vertical plane	<p>1 <input type="radio"/> None</p> <p>2 <input type="radio"/> Fingertips may move anteriorly (pushed up by muscle bulk)</p> <p>3 <input type="radio"/> Whole length of fingers move anteriorly</p> <p>4 <input type="radio"/> Whole fingers move anteriorly; are gripped and pulled in</p> <p>DIS</p>

ALL FIELDS START WITH "PA"





SERIOUS ADVERSE EVENT (SAE) REPORT

all bubbles coded as 1

1. Please mark all that apply for this SAE only:

LOHOSP ○ Hospitalization or prolonged hospitalization

PSHOSP

PDIS ☐ Significant disability or incapacity **→** Date of event: / /
PDDATE Month Day Year

LIFET ○ Life threatening event → Date of event:

 /

 /

LTDATE Month Day Year

CANCER ☐ Cancer → Date of diagnosis: / /
CADATE Month Day Year

2. Date the researcher learned of the event:

 /

 /

Month
Day
Year

3. Diagnosis: (If no diagnosis is available, give main symptoms.)

DIAG 1

DIAG 2

DIAGNOSIS

DIAG4





Draft

Participant ID #	Acrostic	Date Form Completed			Staff ID #	
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	/	<input type="text"/> <input type="text"/>	/	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
ID	ACROS	Month	DATE	Year	STFID	

PRIDE

SERIOUS ADVERSE EVENT (SAE) REPORT

SAENUM

SAE #

4. Outcome (to date) of serious adverse event: (Please mark one.)

0 ☐ Completely recovered **OUTCO**

1 ☐ Recovered with sequelae

2 ☐ Condition improving

3 ☐ Condition present and unchanged

4 ☐ Condition deteriorated

5 ☐ Death due to adverse event **OUTOT**

6 ☐ Other, specify:

5. Participant's status in study: (Please mark one.)

0 ☐ Participant discontinued study → Please complete Termination Report

1 ☐ Participant continued in study **STATUS**

6. Treatment administered for the SAE: (Please mark all that apply.)

NPR ☐ New medication prescription **all bubbles coded as 1**

total duration days **NPRN**

OUTPP ☐ Out-patient procedure

OPR ☐ Out-patient rehabilitation

total days **OPRN**

IPR ☐ In-patient rehabilitation

total length of stay days **IPRN**

SNF ☐ Skilled nursing facility

total length of stay days **SNFN**

NONE ☐ None of the above

ALL FIELDS START WITH "E2"
Page 2 of 3

PRIDE-SAE
Version 1.0, 5/25/04

Draft





Draft

Participant ID #	Acrostic	Date Form Completed			Staff ID #
<div> <div></div> <div></div> <div></div> <div></div> <div></div> </div> <div>ID</div>	<div> <div></div> <div></div> <div></div> <div></div> <div></div> </div> <div>ACROS</div>	<div> <div></div> <div></div> </div> <div>Month</div>	<div> <div></div> <div></div> </div> <div>DATE</div>	<div> <div></div> <div></div> <div></div> <div></div> </div> <div>Year</div>	<div> <div></div> <div></div> <div></div> </div> <div>STFID</div>

PRIDE

SERIOUS ADVERSE EVENT (SAE) REPORT

SAENUM

SAE #

--	--

7. In the opinion of the investigator, is this adverse event related to the study intervention?

- 0 ○ Not related **REL**
 1 ○ Unlikely related
 2 ○ Possibly related
 3 ○ Probably related
 4 ○ Definitely related

8. Comments: (This is for additional information pertinent to event.)

[illegible]

COM1
COM2

COM3

ETC

TO

COM15

9. Principal Investigator's signature _____ **PSTFID** Staff ID # _____

ALL FIELDS START WITH "E3"

10. Form Reviewed by _____

Staff ID #

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RSTFID





Draft

Participant ID #	Acrostic	Date of Visit		Staff ID #
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		<input type="text"/> <input type="text"/> <input type="text"/>
ID	ACROS	Month DATE	Year	STFID

PARTICIPANT SATISFACTION (Self-Administered)

VISIT**6****12****18**

Visit: ☐ 6 months ☐ 12 months ☐ 18 months

Instructions: Please use a black pen and fill in bubbles completely.

1. Compared to before you joined PRIDE, do your urine leakages happen:

0 ☐ Less frequently

1 ☐ About as often

2 ☐ More frequently

LEAFEW

2. Compared to before you joined PRIDE, is the amount of urine you leak each time:

0 ☐ Less

1 ☐ About the same

2 ☐ More

AMT

3. Overall, compared to before you joined PRIDE, do you feel that your leakage of urine is now:

0 ☐ Much less of a problem

1 ☐ Somewhat less of a problem

2 ☐ About the same

3 ☐ Somewhat more of a problem

4 ☐ Much more of a problem

LEANOW

4. Compared to before you joined PRIDE, how satisfied are you with the change in your urine leakage?

0 ☐ Very satisfied

1 ☐ Moderately satisfied

2 ☐ No change in satisfaction

3 ☐ Moderately unsatisfied

4 ☐ Very unsatisfied

SATIS



Draft

PRIDE

Participant ID #	Acrostic	Date of Visit			Staff ID #
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
ID	ACROS	Month	Day	Year	STFID

SEXUAL FUNCTION QUESTIONNAIRE (Self-Administered)

VISIT

 Visit: ☐ -1 SV2 ☐ 0 RV ☐ 6 months ☐ 12 months ☐ 18 months

Instructions: Please use a black pen and fill in bubbles completely.

To keep your responses confidential, please place the completed form in the envelope provided. **The interviewer will not open it.** The data you have provided will be automatically entered into the central database. If you have any questions, you can still ask the interviewer for help.

1. Do you have a spouse or sexual partner at this time?

☐ Yes

☐ No

PART

2. During the past 3 months, how would you rate your level of sexual desire or interest?

☐ 6 Very High

☐ 5 High

☐ 4 Moderate

☐ 3 Low

☐ 2 Very Low

☐ 1 None

DESIRE

3. During the past 3 months, how much has your physical health limited your sexual activity, that is any activity that is **arousing to you, including masturbation**?

☐ 1 Not at all

☐ 2 Slightly →

☐ 3 Moderately →

☐ 4 Quite a bit →

☐ 5 Extremely →

PHYLIM

ALL FIELDS

START WITH "F1"

3a. In what way has your physical health limited **your own** sexual functioning? (Please mark all that apply.)

☐ 1 Pain or discomfort **LPAIN**

☐ 1 Fatigue or low energy **LFAT**

☐ 1 Lack of interest in sex **LLACK**

☐ 1 Difficulty becoming aroused **LDARO**

☐ 1 Difficulty with vaginal lubrication **LDLUB**

☐ 1 Difficulty having an orgasm **LDORG**

☐ 1 Concern about leaking urine **LCLUR**

☐ 1 Embarrassment **LEMB**

☐ 1 Fear of damaging my health **LDHEA**

☐ 1 Other **LOTH**



Draft

Participant ID #	Acrostic	Date of Visit	Staff ID #
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ID	ACROS	<div>Month</div> <div>Day</div> <div>Year</div>	STFID

PRIDE

SEXUAL FUNCTION QUESTIONNAIRE (Self-Administered)

VISIT

Visit: ⁻¹ ○ SV2 ⁰ ○ RV ⁶ ○ 6 months ¹² ○ 12 months ¹⁸ ○ 18 months

4. **During the past 3 months**, on average, how would you rate your overall level of sexual satisfaction?

5 ☐ Very satisfied

SATIS

4 ☐ Moderately satisfied

³ ☐ About equally satisfied and dissatisfied

2 ☐ Moderately dissatisfied

1 ○ Very dissatisfied

5. **During the past 3 months**, have you had any sexual activity, that is any activity that is arousing to you, including **masturbation**? .

1 ☐ Yes → Go to question #6

SEX3M

☐ No

IF NO, Indicate the reason: I am not sexually active because
(Please mark all that apply.)

1 ☐ I am not interested

NNOTI

1 O I do not have a partner at this time **NNPAR**

NNPAR

1 ☐ I have a partner, but my partner is not interested

NPNI

1 ☐ I have a physical problem or illness

NPHYP

that makes sexual activity difficult or uncomfortable

1 ☐ My partner has a physical problem or illness that

NPAPHY

that makes sexual activity difficult or uncomfortable

You have completed this questionnaire.

6. During the past 3 months, typically, how often did you leak urine during sexual activity?

5 ☐ None of the time → Go to question #8

4 ○ A little of the time

SLEAK

3 ☐ Some of the time

2 ☐ Most of the time

1 ☐ All of the time

ALL FIELDS START WITH "F2"





Draft

Participant ID #	Acrostic	Date of Visit	Staff ID #
<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>
ID	ACROS	Month Day Year	STFID

SEXUAL FUNCTION QUESTIONNAIRE (Self-Administered)

VISIT

Visit: ☒ -1 SV2 ☐ 0 RV ☐ 6 6 months ☐ 12 12 months ☐ 18 18 months

7. During the past 3 months, how much did leaking urine during sexual activity bother you?
- 1 ☐ Not at all
 2 ☐ Slightly **LUBOTH**
 3 ☐ Moderately
 4 ☐ Quite a bit
 5 ☐ Extremely
8. During the past 3 months, how much did concern about leaking urine restrict your sexual activity?
- 1 ☐ Not at all
 2 ☐ Slightly
 3 ☐ Moderately **LUFEAR**
 4 ☐ Quite a bit
 5 ☐ Extremely
9. During the past 3 months, how often have you avoided sexual intercourse because of bulging in your vagina or feeling like your insides (bladder, rectum, uterus) were falling out?
- 5 ☐ None of the time
 4 ☐ A little of the time
 3 ☐ Some of the time **FBULG**
 2 ☐ Most of the time
 1 ☐ All of the time
10. During the past 3 months, typically, how frequently did you have sexual activity?
- 1 ☐ Less than monthly
 2 ☐ Monthly (once or more each month) **FRQ**
 3 ☐ Weekly (once or more each week)
 4 ☐ Daily (once or more each day)

ALL FIELDS START WITH "F3"





Draft

Participant ID #	Acrostic	Date of Visit			Staff ID #
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
ID	ACROS	Month	Day	Year	STFID

SEXUAL FUNCTION QUESTIONNAIRE (Self-Administered)

VISIT
 Visit: ☐ -1 ☐ 0 ☐ 6 ☐ 12 ☐ 18
 SV2 RV months months months

11. **During the past 3 months**, how would you rate your level of sexual arousal (turn on) during sexual activity or intercourse?
- 5 ☐ Very High
 4 ☐ High
 3 ☐ Moderate **AROUSE**
 2 ☐ Low
 1 ☐ Very Low or None at All
12. **During the past 3 months**, how difficult was it to become lubricated (wet) during sexual activity or intercourse?
- 5 ☐ Not difficult
 4 ☐ Slightly difficult
 3 ☐ Difficult **WET**
 2 ☐ Very difficult
 1 ☐ Extremely difficult or impossible
13. **During the past 3 months**, when you had sexual stimulation or intercourse, how difficult was it for you to reach orgasm (climax)?
- 5 ☐ Not difficult
 4 ☐ Slightly difficult
 3 ☐ Difficult **ORG**
 2 ☐ Very difficult
 1 ☐ Extremely difficult or impossible
14. **During the past 3 months**, how would you rate your level of discomfort or pain during or following vaginal penetration?
- 0 ☐ I did not attempt intercourse or vaginal penetration
 5 ☐ Very Low or None at All
 4 ☐ Low **PAIN**
 3 ☐ Moderate
 2 ☐ High
 1 ☐ Very High
- ALL FIELDS START WITH "F4"**

Draft





Draft

Participant ID #	Acroscopic	Date of Visit			Staff ID #	
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ID	ACROS	Month	DATE	Year	STFID	

SKILLS-BASED MAINTENANCE PROGRAM EXIT QUESTIONNAIRE

Instructions: Please use a black pen and fill in bubbles completely.

The purpose of these questions is to help us design a better program for the future. So, please be as honest and forthright as possible in your evaluation of your PRIDE program experience. We appreciate your feedback and efforts to help us refine the program.

Section I

	Please rate your experience using the 5 point scale:					
	1 Not at all	2	3 Somewhat	4	5 Extremely	N/A*
1. How useful were the maintenance sessions between months 6 and 18 in helping you lose and/or maintain your weight?	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>	5 <input type="radio"/>	0 <input type="radio"/>
2. How much did you enjoy coming to the maintenance sessions?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Would you recommend the maintenance program to a friend who is working on weight loss?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. How helpful or valuable were the weigh-ins?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. How helpful or valuable was the review of diaries by the therapists?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. How helpful or valuable was it to receive the weight and exercise graphs distributed at some sessions by your group leader?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. How helpful or valuable was it to receive the printed materials (i.e., handouts)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

*N/A= attended too few sessions to rate





Draft

Participant ID #	Acrostic	Date of Visit			Staff ID #
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ID	ACROS	Month	DATE	Year	STFID

SKILLS-BASED MAINTENANCE PROGRAM EXIT QUESTIONNAIRE

Section II

How <u>helpful</u> or <u>valuable</u> were the following specific activities in your weight loss and maintenance efforts?	Please rate your experience using the 5 point scale:					N/A*
	1 Not at all helpful	2	3 Somewhat helpful	4	5 Extremely helpful	
1. The series of lessons related to the holidays	<input type="radio"/> 1 HOLI	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/>
2. Raffles and prizes connected to keeping track of exercising	<input type="radio"/> PRIZ	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Information on volumetrics and energy density	<input type="radio"/> VOLU	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Cooking Demonstration	<input type="radio"/> COOK	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Mindful eating	<input type="radio"/> MIND	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. In-session physical activity (e.g., circuit training, exercise video)	<input type="radio"/> PHYACT	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Learning supermarket strategies	<input type="radio"/> STRAT	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. Watching the video Supersize Me	<input type="radio"/> VSUP	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Discussing emotional eating	<input type="radio"/> EMOEAT	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. Discussing relapse prevention	<input type="radio"/> RELPRE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

*N/A= attended too few sessions to rate





Draft

Participant ID #	Acrostic	Date of Visit			Staff ID #
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ID	ACROS	DATE			STFID

SLEEP QUESTIONNAIRE (Self-Administered)

VISIT
 Visit: ☒ -1 SV2 ☐ 0 RV ☐ 6 6 months ☒ 12 12 months ☐ 18 18 months

Instructions: Please use a black pen and fill in bubbles completely.
Please answer all questions.

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.

1. During the past month, when have you usually gone to bed?

BEDT
 :

usual bedtime

☐ a.m. ☐ p.m.**BDEAP**☐ 0 ☐ 1

2. During the past month, how long (in minutes) has it taken you to fall asleep each night?

MINUT

minutes

3. During the past month, when have you usually gotten up in the morning?

UPT
 :

usual getting up time

☐ a.m. ☐ p.m.**UPAP****UPT2**☐ 0 ☐ 1

4. During the past month, how many hours of **actual sleep** did you get each night?
(This may be different than the number of hours you spent in bed.)

HOURSS

hours of sleep

5. How many hours of sleep do you need each night to feel rested?

HOURS R

hours of sleep

ALL FIELDS START WITH "S1"





Draft

Participant ID #	Acroscopic	Date of Visit			Staff ID #
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ID	ACROS	Month	Day	Year	STFID

SLEEP QUESTIONNAIRE (Self-Administered)

VISITVisit: ☒ **1**SV2 ☐ **0**RV ☐ **6** months ☐ **12** months ☐ **18** months

6. During the past month, how often have you had trouble sleeping because you . . .	Not during the past month 0	Less than once a week 1	Once or twice a week 2	Three or more times a week 3
a. Cannot get to sleep within 30 minutes TW30	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Wake up in the middle of the night or early morning. TMID	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Have to get up to use the bathroom. TUPBR	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Cannot breathe comfortably. TCBC	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Cough or snore loudly. TCSL	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Feel too cold. TCOLD	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Feel too hot. THOT	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Had bad dreams. TDREAM	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Had pain. TPAIN	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Other Reason. TOTH	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	0 Not during the past month	1 Less than once a week	2 Once or twice a week	3 Three or more times a week
7. During the past month, how often have you taken medicine (either prescribed or "over the counter") to help you sleep? TMED	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. During the past month, how often have you had trouble staying awake while driving, eating meals, or engaging in social activities? TWAKE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

ALL FIELDS START WITH "S2"



Draft

PRIDE

Participant ID #	Acrostic	Date of Visit			Staff ID #
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
ID	ACROS	Month	Day	Year	STFID

SLEEP QUESTIONNAIRE (Self-Administered)

VISIT
 Visit: ☐ -1 SV2 ☐ 0 RV ☐ 6 months ☐ 12 months ☐ 18 months

	No problem at all 0	Only a very slight problem 1	Somewhat of a problem 2	A very big problem 3
9. During the past month, how much of a problem has it been for you to keep up enthusiasm to get things done? ENTH	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	0 Very Good	1 Fairly Good	2 Fairly Bad	3 Very Bad
10. During the past month, how would you rate your sleep quality overall? OSQ	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

11. Do you take naps regularly?

☐ 1 Yes ☐ 0 No ☐ 8 Don't Know **RNAPS**

11a. How many days per week do you usually nap?

 days **DNAP**

11b. On average, how many hours do you nap each time?

- ☐ 0 Less than 1 hour
☐ 1 At least 1 hour but no more than 2 hours **HNAP**
☐ 2 More than 2 hours

ALL FIELDS START WITH "S3"



Draft

Participant ID #	Acrostic	Date of Visit	Staff ID #
<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>
ID	ACROS	Month Day Year DATE	STFID

SLEEP QUESTIONNAIRE (Self-Administered)

VISIT
 Visit: ☐ -1 SV2 ☐ 0 RV ☐ 6 6 months ☐ 12 12 months ☐ 18 18 months

12. During the past month, how likely were you to doze off or fall asleep in the following situations, in contrast to feeling just tired? Even if you have not done some of these activities recently, please respond about how they would have affected you.

		0	1	2	3
		Would <u>Never</u> Doze	<u>Slight</u> Chance of Dozing	<u>Moderate</u> Chance of Dozing	<u>High</u> Chance of Dozing
a. Sitting and reading	SITREA <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Watching TV	TV <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Sitting inactive in a public place (e.g. a theater or a meeting)	PUB <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. As a passenger in a car for an hour without a break	PCAR <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Lying down to rest in the afternoon when circumstances permit	NAP <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Sitting and talking to someone	STALK <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Sitting quietly after a lunch without alcohol	LUNNOA <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. In a car, while stopped for a few minutes in traffic	DCAR <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

ALL FIELDS START WITH "S4"





Draft

Participant ID #	Acrostic	Date of Visit	Staff ID #
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ID	ACROS	Month DATE Day Year	STFID

STRESS TESTVisit: 1 ☐ UDS Baseline 7 ☐ UDS 6 months**VISIT****Instructions:** Please use a black pen and fill in bubbles completely.

1. Did the participant demonstrate Stress Urinary Incontinence at a bladder volume ≤ 300 ml during the Stress Test?

1 ☐ Yes 0 ☐ No**SUI**

- 1a. Was the leakage with a detrusor contraction?

1 ☐ Yes, with contraction 0 ☐ No, without contraction**DESC**

- 1b. Did Stress Urinary Incontinence occur at this bladder volume with Valsalva in supine position?

☐ Yes ☐ No ☐ Not Tested**VAL**

- 1c. Did Stress Urinary Incontinence occur at this bladder volume with cough in supine position?

1 ☐ Yes 0 ☐ No 2 ☐ Not Tested**COU**

- 1d. Did Stress Urinary Incontinence occur at this bladder volume with Valsava in standing position?

1 ☐ Yes 0 ☐ No 2 ☐ Not Tested**VALST**

- 1e. Did Stress Urinary Incontinence occur at this bladder volume with cough in standing position?

1 ☐ Yes 0 ☐ No 2 ☐ Not Tested**COUST**

2. Was it necessary to reduce a Stage III or IV anterior prolapse to complete this Stress Test?

1 ☐ Yes 0 ☐ No**PRO****ALL FIELDS START WITH "ST"**



Draft

PRIDE

Participant ID #	Acrostic	Date of Visit			Staff ID #	
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	/	<input type="text"/> <input type="text"/>	/	<input type="text"/> <input type="text"/> <input type="text"/>
ID	ACROS	Month	DATE	Year	STFID	

STRUCTURED EDUCATION PROGRAM EXIT QUESTIONNAIRE

Instructions: Please use a black pen and fill in bubbles completely.

The purpose of this question is to help us design a better program for the future. So, please be as honest and forthright as possible in your evaluation of your PRIDE program experience. We appreciate your feedback and efforts to help us refine the program.

1. If we were to do the PRIDE study again, would you encourage us to offer the SEP (Structured Education Program) just as we offered the program to you or offer no class sessions and just have only the follow-up assessment visits at 6, 12 and 18 months ?

Offer no SEP groups but attend 6, 12, 18 month follow-up visits	SEPQ				Offer SEP just as we did in PRIDE
1	2	3	4	5	
1	2	3	4	5	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	





Draft





Draft

Participant ID #	Acrostic	Date of Visit			Staff ID #
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ID	ACROS	DATE			STFID

UI SYMPTOMS QUESTIONNAIRE (Self-Administered)

Visit: ☐ 0 ☐ RV ☐ 6 months ☐ 12 months ☐ 18 months

VISIT

Instructions: Please use a black pen and fill in bubbles completely.

1. During the past 1month, did you leak urine...			How much urine do you typically lose with each episode?	How much does this leakage bother you?	How does this leakage affect your day-to-day activities?
1a. When you were performing some physical activity such as coughing, sneezing, lifting, or exercising?	0 <input type="radio"/> No (Go to question #1b)	1 <input type="radio"/> Yes ↳	0 <input type="radio"/> Drops 1 <input type="radio"/> Small splashes (1-2 teaspoons) 2 <input type="radio"/> More	0 <input type="radio"/> Not at all 1 <input type="radio"/> Slightly 2 <input type="radio"/> Moderately 3 <input type="radio"/> Quite a bit 4 <input type="radio"/> Extremely	0 <input type="radio"/> Not at all 1 <input type="radio"/> Slightly 2 <input type="radio"/> Moderately 3 <input type="radio"/> Quite a bit 4 <input type="radio"/> Extremely
1b. When you had the urge or the feeling that you needed to empty your bladder but you could not get to the toilet fast enough?	0 <input type="radio"/> No (Go to question #1c)	1 <input type="radio"/> Yes ↳	0 <input type="radio"/> Drops 1 <input type="radio"/> Small splashes (1-2 teaspoons) 2 <input type="radio"/> More	0 <input type="radio"/> Not at all 1 <input type="radio"/> Slightly 2 <input type="radio"/> Moderately 3 <input type="radio"/> Quite a bit 4 <input type="radio"/> Extremely	0 <input type="radio"/> Not at all 1 <input type="radio"/> Slightly 2 <input type="radio"/> Moderately 3 <input type="radio"/> Quite a bit 4 <input type="radio"/> Extremely
1c. Without any physical activity or without a sense of urgency?	0 <input type="radio"/> No (Go to question #2)	1 <input type="radio"/> Yes ↳	0 <input type="radio"/> Drops 1 <input type="radio"/> Small splashes (1-2 teaspoons) 2 <input type="radio"/> More	0 <input type="radio"/> Not at all 1 <input type="radio"/> Slightly 2 <input type="radio"/> Moderately 3 <input type="radio"/> Quite a bit 4 <input type="radio"/> Extremely	0 <input type="radio"/> Not at all 1 <input type="radio"/> Slightly 2 <input type="radio"/> Moderately 3 <input type="radio"/> Quite a bit 4 <input type="radio"/> Extremely





Draft

Participant ID #	Acrostic	Date of Visit	Staff ID #
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ID	ACROS	Month DATE Day Year	STFID

UI SYMTPOMS QUESTIONNAIRE (Self-Administered)

Visit: ☐ 0 ☐ RV ☐ 6 months ☐ 12 months ☐ 18 months **VISIT**

2. During the past 1 month, have you done any of the following to help manage your urine leakage? (Please mark all that apply.)

DECFLU ☐ Decrease how much fluid I drink

WPAD ☐ Wear protective pads (panty liners, incontinence pads)

**ALL BUBBLES IN Q. 2
CODED AS 1**

NBATH ☐ Stay near a bathroom

KBATH ☐ Know where bathrooms are when I go out

UFREQ ☐ Urinate frequently (every 2 hours or less) to avoid accidents

LTRAV ☐ Limit my travel, social or recreational activities

APHY ☐ Avoid physical activities that may cause leakage of urine

KEGEL ☐ Do exercises to strengthen muscles near my bladder (Kegel exercises)

OTH ☐ Other

NON ☐ None of the above

<p>3. In the past 1 month, how frequently, on average, did you urinate during the day? (from the time you get up in the morning to the time you go to bed at night)</p>	<p>How much has this frequency of daytime urination bothered you?</p>	<p>How much has this frequency of daytime urination affected your day-to-day activities?</p>
<p>0 <input type="radio"/> At least once every 30 minutes</p> <p>1 <input type="radio"/> At least once every hour</p> <p>2 <input type="radio"/> At least once every 2 hours</p> <p>3 <input type="radio"/> At least once every 3 hours</p> <p>4 <input type="radio"/> At least once every 4 to 8 hours</p> <p>5 <input type="radio"/> At least once every 9 or more hours</p>	<p>0 <input type="radio"/> Not at all</p> <p>1 <input type="radio"/> Slightly</p> <p>2 <input type="radio"/> Moderately</p> <p>3 <input type="radio"/> Quite a bit</p> <p>4 <input type="radio"/> Extremely</p>	<p>0 <input type="radio"/> Not at all</p> <p>1 <input type="radio"/> Slightly</p> <p>2 <input type="radio"/> Moderately</p> <p>3 <input type="radio"/> Quite a bit</p> <p>4 <input type="radio"/> Extremely</p>
FREQD	BOTHD	AFFD





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PRIDE

Participant ID #	Acrostic	Date of Visit			Staff ID #
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ID	ACROS	Month	Day	Year	STFID

UI SYMPTOMS QUESTIONNAIRE (Self-Administered)

Visit: ☐ 0 ☐ RV ☐ 6 months ☐ 12 months ☐ 18 months

VISIT

<p>4. In the past 1 month, how many times, on average, did you urinate during the night? (from the time you go to bed at night until the time you get up in the morning)</p> <p>FREQN</p> <p><input type="radio"/> 0 times → go to question # 5.</p> <p><input type="radio"/> 1 time</p> <p><input type="radio"/> 2 times</p> <p><input type="radio"/> 3 times</p> <p><input type="radio"/> 4 or more times</p>	<p>How much has this frequency of nighttime urination bothered you?</p> <p>BOTHN</p> <p><input type="radio"/> 0 Not at all</p> <p><input type="radio"/> 1 Slightly</p> <p><input type="radio"/> 2 Moderately</p> <p><input type="radio"/> 3 Quite a bit</p> <p><input type="radio"/> 4 Extremely</p>	<p>How much has this frequency of nighttime urination affected your day-to-day activities?</p> <p>AFFN</p> <p><input type="radio"/> 0 Not at all</p> <p><input type="radio"/> 1 Slightly</p> <p><input type="radio"/> 2 Moderately</p> <p><input type="radio"/> 3 Quite a bit</p> <p><input type="radio"/> 4 Extremely</p>
---	---	---

5. During the past 1 month, how often did you typically feel a strong or overwhelming urge to urinate, whether or not you urinated or leaked urine? (Do not include a weak or slight urge to urinate.)

☐ 0 Never → Go to Question # 10.

☐ 1 Less than weekly (1-3 times) → Go to Question # 10.

☐ 2 Weekly (once or more each week) → Go to Question # 6.

☐ 3 Daily (once or more each day) → Go to Question # 6. **OFTEN**

6. During the past 1 month, with how many of your urinations or urine leaks have you felt a strong or overwhelming urge to urinate?

☐ 0 Never or less than a quarter of the time

☐ 1 A quarter of the time

☐ 2 Half of the time

☐ 3 Three-quarters of the time

☐ 4 Almost always

STRONG



Draft

Participant ID #	Acrostic	Date of Visit			Staff ID #	
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ID	ACROS	Month	DATE	Day	Year	STFID

UI SYMPTOMS QUESTIONNAIRE (Self-Administered)

Visit: **0** ☐ RV ☐ **6** months ☐ **12** months ☐ **18** months **VISIT**

7. During the past 1 month, how much has this strong or overwhelming urge to urinate bothered you? (Please mark one.)

0 ☐ Not at all

1 ☐ Slightly

SUBOTH

2 ☐ Moderately

3 ☐ Quite a bit

4 ☐ Extremely

8. During the past 1 month, how much has this strong or overwhelming urge to urinate affected your day-to-day activities? (Please mark one.)

0 ☐ Not at all

1 ☐ Slightly

UAFPEC

2 ☐ Moderately

3 ☐ Quite a bit

4 ☐ Extremely

9. During the past 1 month, when I felt a strong or overwhelming urge to urinate: (Please mark one.)

0 ☐ I was usually able to finish what I was doing before going to the toilet.

1 ☐ I was usually able to hold urine until I reached the toilet if I go immediately.

2 ☐ I was usually not able to hold urine.

WHEN

10. During the past 1 month, which one of the following has **bothered** you the most? (Please mark one.)

0 ☐ Frequently going to the bathroom during the day

1 ☐ Frequently going to the bathroom during the night

MOSTBO

2 ☐ My strong or overwhelming urge to urinate

3 ☐ My leakage of urine

4 ☐ I was not bothered by my bladder symptoms





Draft

Participant ID #	Acrostic	Date of Visit	Staff ID #
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ID	ACROS	Month DATE Day Year	STFID

UI SYMPTOMS QUESTIONNAIRE (Self-Administered)

Visit: ☐ 0 ☐ RV ☐ 6 months ☐ 12 months ☐ 18 months **VISIT**

11. During the past 1 month , how often have you ...	Frequency during the past month	How much has this bothered you?	How much has this affected your day-to-day activities?
11a. Had a sensation of not emptying your bladder completely after you finish urinating? →	0 <input type="radio"/> Not at all (go to #11b) 1 <input type="radio"/> Less than 1 time in 5 2 <input type="radio"/> Less than half the time 3 <input type="radio"/> About half the time 4 <input type="radio"/> More than half the time 5 <input type="radio"/> Almost always FRNE	0 <input type="radio"/> Not at all 1 <input type="radio"/> Slightly 2 <input type="radio"/> Moderately 3 <input type="radio"/> Quite a bit 4 <input type="radio"/> Extremely BONE	0 <input type="radio"/> Not at all 1 <input type="radio"/> Slightly 2 <input type="radio"/> Moderately 3 <input type="radio"/> Quite a bit 4 <input type="radio"/> Extremely AFNE
11b. Had to urinate again less than 2 hours after you finished urinating? →	0 <input type="radio"/> Not at all (go to #11c) 1 <input type="radio"/> Less than 1 time in 5 2 <input type="radio"/> Less than half the time 3 <input type="radio"/> About half the time 4 <input type="radio"/> More than half the time 5 <input type="radio"/> Almost always FRUA	0 <input type="radio"/> Not at all 1 <input type="radio"/> Slightly 2 <input type="radio"/> Moderately 3 <input type="radio"/> Quite a bit 4 <input type="radio"/> Extremely BOUA	0 <input type="radio"/> Not at all 1 <input type="radio"/> Slightly 2 <input type="radio"/> Moderately 3 <input type="radio"/> Quite a bit 4 <input type="radio"/> Extremely AFUA
11c. Found that you stopped and started again several times when you urinate? →	0 <input type="radio"/> Not at all (go to #11d) 1 <input type="radio"/> Less than 1 time in 5 2 <input type="radio"/> Less than half the time 3 <input type="radio"/> About half the time 4 <input type="radio"/> More than half the time 5 <input type="radio"/> Almost always FRSS	0 <input type="radio"/> Not at all 1 <input type="radio"/> Slightly 2 <input type="radio"/> Moderately 3 <input type="radio"/> Quite a bit 4 <input type="radio"/> Extremely BOSS	0 <input type="radio"/> Not at all 1 <input type="radio"/> Slightly 2 <input type="radio"/> Moderately 3 <input type="radio"/> Quite a bit 4 <input type="radio"/> Extremely AFSS
11d. Found it difficult to postpone urination? →	0 <input type="radio"/> Not at all (go to #11e) 1 <input type="radio"/> Less than 1 time in 5 2 <input type="radio"/> Less than half the time 3 <input type="radio"/> About half the time 4 <input type="radio"/> More than half the time 5 <input type="radio"/> Almost always FRPU	0 <input type="radio"/> Not at all 1 <input type="radio"/> Slightly 2 <input type="radio"/> Moderately 3 <input type="radio"/> Quite a bit 4 <input type="radio"/> Extremely BOPU	0 <input type="radio"/> Not at all 1 <input type="radio"/> Slightly 2 <input type="radio"/> Moderately 3 <input type="radio"/> Quite a bit 4 <input type="radio"/> Extremely AFPU





Draft

PRIDE

Participant ID #	Acrostic	Date of Visit			Staff ID #
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
ID	ACROS	Month	Day	Year	STFID

UI SYMPTOMS QUESTIONNAIRE (Self-Administered)

Visit: ☐ 0 ☐ RV ☒ 6 months ☐ 12 months ☐ 18 months **VISIT**

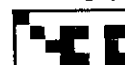
11. During the past 1 month , how often have you ...	Frequency during the past month	How much has this bothered you?	How much has this affected your day-to-day activities?
11e. Had a weak urinary stream? →	0 <input type="radio"/> Not at all (go to #11f) 1 <input type="radio"/> Less than 1 time in 5 2 <input type="radio"/> Less than half the time 3 <input type="radio"/> About half the time 4 <input type="radio"/> More than half the time 5 <input type="radio"/> Almost always FRWS	0 <input type="radio"/> Not at all 1 <input type="radio"/> Slightly 2 <input type="radio"/> Moderately 3 <input type="radio"/> Quite a bit 4 <input type="radio"/> Extremely BOWS	0 <input type="radio"/> Not at all 1 <input type="radio"/> Slightly 2 <input type="radio"/> Moderately 3 <input type="radio"/> Quite a bit 4 <input type="radio"/> Extremely AFWS
11f. Had to push or strain to begin urination? →	0 <input type="radio"/> Not at all (go to #12) 1 <input type="radio"/> Less than 1 time in 5 2 <input type="radio"/> Less than half the time 3 <input type="radio"/> About half the time 4 <input type="radio"/> More than half the time 5 <input type="radio"/> Almost always	0 <input type="radio"/> Not at all 1 <input type="radio"/> Slightly 2 <input type="radio"/> Moderately 3 <input type="radio"/> Quite a bit 4 <input type="radio"/> Extremely	0 <input type="radio"/> Not at all 1 <input type="radio"/> Slightly 2 <input type="radio"/> Moderately 3 <input type="radio"/> Quite a bit 4 <input type="radio"/> Extremely

FRPS

BOPS

AFPS

ALL FIELDS START WITH "U6"





Draft

PRIDE

Participant ID #	Acrostic	Date of Visit			Staff ID #
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
ID	ACROS	Month	Day	Year	STFID

UI SYMPTOMS QUESTIONNAIRE (Self-Administered)

Visit: **0** ☐ RV ☐ **6** months ☐ **12** months ☐ **18** months **VISIT**

12. **During a typical week**, how many of each of the supplies listed below do you use specifically for your urine leakage?

Product	Number per week	
Pantyliners or minipads	<input type="text"/>	PANTY
Maxipads such as Kotex or Modess	<input type="text"/>	MAXI
Incontinence Pads such as Serenity or Poise	<input type="text"/>	IPAD
Disposable undergarments or protective underwear	<input type="text"/>	DIAP
Urethral inserts such as Femsoft	<input type="text"/>	UREI
Toilet paper - (record number of <u>changes</u>)	<input type="text"/>	PAPER
Paper towels - (record number of <u>sheets</u>)	<input type="text"/>	TOIP
Other (Please describe what you used): OTHTXT <input type="text"/>	<input type="text"/>	OTHER

13. **During a typical week**, how many loads of wash do you do **because** of your urine leakage?

0 ☐ None **3** ☐ 3 **6** ☐ 6
1 ☐ 1 **4** ☐ 4 **7** ☐ 7
2 ☐ 2 **5** ☐ 5 **8** ☐ 8 or more

LOAD

ALL FIELDS START WITH "U7"





Draft

PRIDE

Participant ID #	Acrostic	Date of Visit	Staff ID #
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
ID	ACROS	Month DATE Day Year	STFID

UI SYMPTOMS QUESTIONNAIRE (Self-Administered)

Visit: ⁰ ☐ RV ⁶ ☐ 6 months ¹² ☐ 12 months ¹⁸ ☐ 18 months **VISIT**

14. During a typical week, how many items of clothing do you dry clean because of your urine leakage?

0 1 2 3 4 5 6 7 8

Type of clothing		Number dry cleaned per week								
		None	1	2	3	4	5	6	7	8 or more
Pants	PANTS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Skirt	SKIRT	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dress	DRESS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Suit	SUIT	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Blouse	BLOUSE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other (Please describe)	OTHER	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	OTHTXT									

15. During the past 1 month, have your pelvic organs (uterus, bladder, or rectum) been dropping out of your vagina causing a feeling of bulging, pressure, or protrusion or a sensation like your "insides are coming out"? (This is sometimes called prolapse.)

1 ☐ Yes **PROLA**

0 ☐ No → Go to Question #16

8 ☐ Don't Know → Go to Question #16

- 15a. During the past 1 month, have you had a bulge from your vagina or something falling out of your vagina that you can see or touch?

1 ☐ Yes **BULGE**

0 ☐ No

8 ☐ Don't Know

ALL FIELDS START WITH "U8"





PCIDE

Participant ID #	Acrostic	Date of Visit			Staff ID #
<div><div></div><div></div><div></div><div></div><div></div></div>	<div><div></div><div></div><div></div><div></div><div></div></div>	<div><div></div><div></div></div> / <div><div></div><div></div></div> / <div><div></div><div></div><div></div><div></div></div>			
ID	ACROS	Month	DATE	Year	

UI SYMPTOMS QUESTIONNAIRE (Self-Administered)

Visit: ☒ 0 ☐ RV ☐ 6 months ☐ 12 months ☐ 18 months VISIT

16. In a typical day, how many glasses (6 ounce glasses) do you drink of each of the following **non-alcoholic** beverages?

[illegible]

17. Please indicate how bothersome the following symptoms have been in the last month:

	Not at all 0	Slightly 1	Moderately 2	Quite a bit 3	Extremely 4
a. Hot flashes or flushes FLA	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Sleep disturbance (difficulty falling to sleep, staying asleep or early wakening) SLP	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Vaginal dryness VAGD	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>





Draft

PRIDE

Participant ID #	Acrostic	Date of Visit	Staff ID #
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
ID	ACROS	Month DATE Day Year	STFID

URETHRAL HYPERMOBILITY (Q-TIP TEST)

VISIT Visit: ☐ UDS Baseline ☒ UDS 6 months

Instructions: Please use a black pen and fill in bubble completely.

1. Resting Angle: ¹ ☐ + degrees
² ☐ -

PLRA REST

2. Angle at maximum straining: ¹ ☐ + degrees
² ☐ -

PLMI

MAX

ALL FIELDS START WITH "QT"





Draft

Participant ID #	Acrostic	Date of Visit	Staff ID #
<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>
ID	ACROS	Month DATE Day Year	STFID

UROGENITAL DISTRESS INVENTORY (UDI) (Self-Administered)

VISIT Visit: ☐ 0 RV ☐ 6 6 months ☐ 12 12 months ☐ 18 18 months

Instructions: Please use a black pen and fill in bubbles completely.

These questions deal with your accidental urine loss and/or prolapse.

1. The following symptoms have been described by women who experience accidental urine loss and/or prolapse. Please indicate which symptoms you are experiencing, and how bothersome they are for you. Be sure to answer all items.

	If YES, how much does it bother you?					
	No	Yes	Not at all	Slightly	Moderately	Greatly
A. Do you experience frequent urination? FU	<input type="radio"/> 0	<input type="radio"/> 1 →	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
B. Do you feel a strong feeling of urgency to empty your bladder? UR	<input type="radio"/>	<input type="radio"/> →	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. Do you experience urine leakage related to the feeling of urgency? UL	<input type="radio"/>	<input type="radio"/> →	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D. Do you experience urine leakage related to physical activity, coughing or sneezing? PA	<input type="radio"/>	<input type="radio"/> →	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
E. Do you experience urine leakage not related to urgency or activity? NR	<input type="radio"/>	<input type="radio"/> →	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F. Do you experience small amounts of urine leakage (that is, drops)? SA	<input type="radio"/>	<input type="radio"/> →	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
G. Do you experience large amounts of urine leakage? LA	<input type="radio"/>	<input type="radio"/> →	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
H. Do you experience nighttime urination? NU	<input type="radio"/>	<input type="radio"/> →	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I. Do you experience bedwetting? BW	<input type="radio"/>	<input type="radio"/> →	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>





Draft

Participant ID #	Acrostic	Date of Visit	Staff ID #
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
ID	ACROS	Month DATE Day Year	STFID

UROGENITAL DISTRESS INVENTORY (UDI) (Self-Administered)

VISIT Visit: ☐ RV ☐ 6 months ☒ 12 months ☐ 18 months

			If YES, how much does it bother you?			
	No	Yes	Not at all	Slightly	Moderately	Greatly
J. Do you experience difficulty emptying your bladder? EB	<input type="radio"/> 0	<input type="radio"/> 1 →	<input type="radio"/> 0 EBBO	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
K. Do you experience a feeling of incomplete bladder emptying? IB	<input type="radio"/>	<input type="radio"/> →	<input type="radio"/> IBBO	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
L. Do you experience lower abdominal pressure? LA	<input type="radio"/>	<input type="radio"/> →	<input type="radio"/> LABO	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
M. Do you experience pain when urinating? PU	<input type="radio"/>	<input type="radio"/> →	<input type="radio"/> PUBO	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
N. Do you experience pain in the lower abdominal or genital area? GA	<input type="radio"/>	<input type="radio"/> →	<input type="radio"/>	<input type="radio"/> GABO	<input type="radio"/>	<input type="radio"/>
O. Do you experience heaviness or dis ness in the pelvic area? HD	<input type="radio"/>	<input type="radio"/> →	<input type="radio"/>	<input type="radio"/> HDBO	<input type="radio"/>	<input type="radio"/>
P. Do you experience a feeling of bulging or protrusion in the vaginal area? PR	<input type="radio"/>	<input type="radio"/> →	<input type="radio"/>	<input type="radio"/> PRBO	<input type="radio"/>	<input type="radio"/>
Q. Do you experience bulging or protrusion that you can see in the vaginal area? SP	<input type="radio"/>	<input type="radio"/> →	<input type="radio"/>	<input type="radio"/> SPBO	<input type="radio"/>	<input type="radio"/>
R. Do you experience pelvic discomfort when standing or physically exerting yourself? PD	<input type="radio"/>	<input type="radio"/> →	<input type="radio"/>	<input type="radio"/> PDBO	<input type="radio"/>	<input type="radio"/>
S. Do you have to push on the vaginal walls to have a bowel movement? PW	<input type="radio"/>	<input type="radio"/> →	<input type="radio"/>	<input type="radio"/> PWBO	<input type="radio"/>	<input type="radio"/>
T. Other symptoms OS	<input type="radio"/>	<input type="radio"/> →	<input type="radio"/>	<input type="radio"/> OSBO	<input type="radio"/>	<input type="radio"/>

2. Please go back and review all the symptoms listed for question 1 (A-T). Write the letter of the symptom which has bothered you the most.

LETTER (Please write in only one letter)





Draft

Participant ID #	Acrostic	Date of Visit	Staff ID #
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
ID	ACROS	Month DATE Day Year	STFID

VITAL SIGNS

-2 -1 0 6 12 18

Visit: ☐ SV1 ☐ SV2 ☐ RV ☐ 6 months ☐ 12 months ☐ 18 months

Instructions: Please use a black pen and fill in bubbles completely. If possible, use same arm for all visits.

VISIT**Blood Pressure****1****2****ARM**

Arm Used ☐ Right ☐ Left

Sitting Blood Pressure Measurement

Systolic

mmHg

BP1SY

Diastolic

mmHg

BP1DI**Pulse**

RP

Beats per minute

ALL FIELDS START WITH "VS"



WEIGHT/ABDOMINAL CIRCUMFERENCE

0 3 6 12 18

Visit: ☐ RV ☐ 3 months ☐ 6 months ☐ 12 months ☐ 18 months

VISIT

			-	ka
--	--	--	---	----

kg

3. The average of Measurement 1 and Measurement 2 =

				kg
--	--	--	--	----

_____ cm

_____ cm

Measurement 1 & Measurement 2

cm

If difference between Measurement 1 and Measurement 2 is ≥ 1 cm, do Measurement 3.

_____ cm

ALL FIELDS START WITH "WA"





1026

Participant ID #	Acrostic	Date of Visit	Staff ID #
<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>
ID	ACROS	Month DATE Day Year	STEID

PRIDE II ENROLLMENT FORM

VISIT

Visit: ²⁴ ● 24 months

Instructions: Please use a black pen and fill in bubbles completely.
Please choose one response only.

ROLL

- 0** ○ Participant has signed the consent form and agreed to enroll in PRIDE II.
- 1** ○ Participant terminated early from PRIDE and does not want to enroll in PRIDE II.
- 2** ○ Participant completed 18 Month Visit, but does not want to enroll in PRIDE II.



Primary reason for not enrolling in PRIDE II (select most important reason only)

REASON

- ☐ Illness/medical condition

Please specify:

[illegible]

ILL

- 1** ○ Unwilling to sign consent; refused (no reason)

- 2** ○ No change in incontinence symptoms during PRIDE

- 3** ☐ No change in weight during PRIDE

- 4** ○ Moved from the area

- Transportation problems

- 6** ○ Schedule conflicts/time constraints

- Family problems

- 8** ☐ Other - please specify:

[illegible]

OTH

ALL FIELDS START WITH "EN"



Draft

Participant ID #	Acrostic	Date of Visit		Staff ID #
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
W1ID	W1ACROS	Month	Day	W1STFID

WILLINGNESS TO PAY FOR INCONTINENCE IMPROVEMENT

Participant Instruction: Please respond to these questions about how much money you would be willing to pay **out of your own pocket** for the treatments described. Assume that payments for these treatments are not covered by your health insurance or HMO, Medicare or Medicaid and that you must pay for them **out of your own pocket**.

1. Treatment for Incontinence:

a) Imagine that a new treatment for incontinence becomes available that has no side effects. This new treatment reduces the number of times you leak urine **by one quarter (25%)**.

For example, if you currently leak urine 4 times a day, with this new treatment you would leak urine only 3 times a day. Or if you leak urine every day, this would be reduced to 3 days out of 4.

What is the most money that you would be willing to pay per month **out of your own pocket** for this treatment? (**Fill in one circle only.**)

- | | | | | |
|-------------------------------------|-------------------------------------|-------------------------------------|---------------------------------------|---|
| 0 <input type="radio"/> \$0 | 3 <input type="radio"/> \$15 | 6 <input type="radio"/> \$30 | 9 <input type="radio"/> \$75 | 12 <input type="radio"/> \$200 or more |
| 1 <input type="radio"/> \$5 | 4 <input type="radio"/> \$20 | 7 <input type="radio"/> \$40 | 10 <input type="radio"/> \$100 | W1PAY25 |
| 2 <input type="radio"/> \$10 | 5 <input type="radio"/> \$25 | 8 <input type="radio"/> \$50 | 11 <input type="radio"/> \$150 | |

b) Imagine that a new treatment for incontinence becomes available that has no side effects. This new treatment reduces the number of times you leak urine **by half (50%)**.

For example, if you currently leak urine 4 times a day, with this new treatment you would leak urine only 2 times a day. Or if you leak urine every day, this would be reduced to 2 days out of 4.

What is the most money that you would be willing to pay per month **out of your own pocket** for this treatment? (**Fill in one circle only.**)

- | | | | | |
|-------------------------------------|-------------------------------------|-------------------------------------|---------------------------------------|---|
| 0 <input type="radio"/> \$0 | 3 <input type="radio"/> \$15 | 6 <input type="radio"/> \$30 | 9 <input type="radio"/> \$75 | 12 <input type="radio"/> \$200 or more |
| 1 <input type="radio"/> \$5 | 4 <input type="radio"/> \$20 | 7 <input type="radio"/> \$40 | 10 <input type="radio"/> \$100 | W1PAY50 |
| 2 <input type="radio"/> \$10 | 5 <input type="radio"/> \$25 | 8 <input type="radio"/> \$50 | 11 <input type="radio"/> \$150 | |



Draft

Participant ID #	Acrostic	Date of Visit			Staff ID #
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
W2ID	W2ACROS	Month	Day	Year	W2STFID

WILLINGNESS TO PAY FOR INCONTINENCE IMPROVEMENT

1. Treatment for Incontinence (Continued):

c) Imagine that a new treatment for incontinence becomes available that has no side effects. This new treatment reduces the number of times you leak urine by **three quarters (75%)**.

For example, if you currently *leak urine* 4 times a day, with this new treatment you would *leak urine* only 1 time a day. Or if you *leak urine* every day, this would be reduced to 1 day out of 4.

What is the most money that you would be willing to pay per month **out of your own pocket** for this treatment? (*Fill in one circle only.*)

0 ☐ \$0 **3** ☐ \$15 **6** ☐ \$30 **9** ☐ \$75 **12** ☐ \$200 or more

1 ☐ \$5 **4** ☐ \$20 **7** ☐ \$40 **10** ☐ \$100

2 ☐ \$10 **5** ☐ \$25 **8** ☐ \$50 **11** ☐ \$150

W2PAY75

d) Imagine that a new treatment for incontinence becomes available that has no side effects. This new treatment cures your urine loss so that **you do not leak urine**.

What is the most money that you would be willing to pay per month **out of your own pocket** for this treatment? (*Fill in one circle only.*)

0 ☐ \$0 **3** ☐ \$15 **6** ☐ \$30 **9** ☐ \$75 **12** ☐ \$200 or more

1 ☐ \$5 **4** ☐ \$20 **7** ☐ \$40 **10** ☐ \$100

2 ☐ \$10 **5** ☐ \$25 **8** ☐ \$50 **11** ☐ \$150

W2PAYALL





Draft

Participant ID #	Acrostic	Date of Visit		Staff ID #
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
W3ID	W3ACROS	Month	Day	W3STFID
			Year	

WILLINGNESS TO PAY FOR INCONTINENCE IMPROVEMENT

2. Which of the following categories best represents **your total personal income**, including wages, social security, pensions, interest, dividends, etc. for the past 12 months?

(Fill in one circle only.)

- | | |
|--|---|
| 0 <input type="radio"/> Less than \$5,000 | 7 <input type="radio"/> \$100,000 - \$119,999 |
| 1 <input type="radio"/> \$5,000 - \$9,999 | 8 <input type="radio"/> \$120,000 - \$139,999 |
| 2 <input type="radio"/> \$10,000 - \$19,000 | 9 <input type="radio"/> \$140,000 - \$159,999 |
| 3 <input type="radio"/> \$20,000 - \$39,999 | 10 <input type="radio"/> \$160,000 - \$179,999 |
| 4 <input type="radio"/> \$40,000 - \$59,999 | 11 <input type="radio"/> \$180,000 or more |
| 5 <input type="radio"/> \$60,000 - \$79,999 | 12 <input type="radio"/> Don't know |
| 6 <input type="radio"/> \$80,000 - \$99,999 | |

W3INCPER

3. Which of the following categories best represents the **combined or total income of your household**, including wages, social security, pensions, interest, dividends, etc. for the past 12 months?

(Fill in one circle only.)

- | | |
|--|---|
| 0 <input type="radio"/> Less than \$5,000 | 7 <input type="radio"/> \$100,000 - \$119,999 |
| 1 <input type="radio"/> \$5,000 - \$9,999 | 8 <input type="radio"/> \$120,000 - \$139,999 |
| 2 <input type="radio"/> \$10,000 - \$19,000 | 9 <input type="radio"/> \$140,000 - \$159,999 |
| 3 <input type="radio"/> \$20,000 - \$39,999 | 10 <input type="radio"/> \$160,000 - \$179,999 |
| 4 <input type="radio"/> \$40,000 - \$59,999 | 11 <input type="radio"/> \$180,000 or more |
| 5 <input type="radio"/> \$60,000 - \$79,999 | 12 <input type="radio"/> Don't know |
| 6 <input type="radio"/> \$80,000 - \$99,999 | |

W3INCHOU

4. How many people, including yourself, are supported on this income?

- | | |
|----------------------------------|--|
| 1 <input type="radio"/> 1 | 5 <input type="radio"/> 5 |
| 2 <input type="radio"/> 2 | 6 <input type="radio"/> 6 |
| 3 <input type="radio"/> 3 | 7 <input type="radio"/> 7 |
| 4 <input type="radio"/> 4 | 8 <input type="radio"/> 8 or more |

W3INCSUP

