

My Health - Part B

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| PID: 0 | Acrostic: 0 | Visit: |
| Completed: d_form | Date Form | Administration Type: admin |
| Reviewed by: compby | Language: language | |

C. Urinary History

The following questions are about your urinary or bladder habits. These questions may seem personal or embarrassing, but your answers are important for research on these common health issues.

1. **In the past 12 months**, have you been told by a doctor that you had an infection of your bladder (urinary tract infection) or kidneys?

urinf12

- 1 Yes
- 2 No
- 3 Don't know

→If Yes,

- a. urblinf Number of bladder (urinary tract) infections **in the last year**
- b. urkdinf Number of kidney infections **in the last year**

2. In the **past 7 days**, on average, how many times each day have you had **to go to the bathroom to urinate**:

- a. During the day? urday **times per day**
- b. During the night after going to bed? urnight **times per night**

3. Many people complain that they leak urine or wet themselves accidentally. In the **past 12 months**, have you **leaked even a small amount of urine?** (*check one only*)

urleak12

- 1 None
- 2 Less than once a month
- 3 One or more times per month
- 4 One or more times per week
- 5 Every day

4. Have you leaked even a small amount of urine or wet yourself **in the past 7 days?**

urleak7

- 1 Yes
- 2 No

→ If Yes, in the past 7 days, how many times did you leak

urine with...

a. **urcough** value="1" An activity like coughing, sneezing, lifting or exercise.

urcghcnt **times in the last week**

b. **ururge** value="1" An urge to urinate and couldn't get to the bathroom fast enough.

ururgcnt **times in the last week**

c. **urother** value="1" Other reasons or don't know.

urothcnt **times in the last week**

MY HEALTH, PART B.

| | | | | | | | |
|---------------------|-----------------------|---------------------|--|----------------------|-------------|----------------------|---|
| Patient ID | [affix ID label here] | Date Form Completed | <input type="text"/> / <input type="text"/> / <input type="text"/> | Month | Day | Year | |
| Administration Type | <input type="text"/> | Visit Code | <input type="text"/> | <input type="text"/> | Reviewed by | <input type="text"/> | |
| | | | | | | Language | E |

A. Complaints

Below is a list of complaints people sometime have. For each item, check the one that best describes how bothersome the complaint was for you during the past 4 weeks. Be sure to mark one box for each complaint listed. If you did not have the problem, please check the box under "did not occur." If you had the complaint, use the following key to indicate how bothersome it was:

Mild = complaint did not interfere with usual activities.

Moderate = complaint interfered somewhat with usual activities.

Severe = complaint was so bothersome that usual activities could not be performed

| Complaint | Did not occur | Complaint occurred and was: | | |
|--|----------------------------|-----------------------------|----------------------------|----------------------------|
| | | Mild | Moderate | Severe |
| 1. Heartburn (burning sensation in chest or upper abdomen) | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| 2. Regurgitation (the involuntary movement of liquids or foods from the stomach up into the throat) | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| 3. Nausea (feeling sick to your stomach as if you were going to throw up or vomit) | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| 4. Abdominal pain above the navel | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| 5. Vomiting | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| 6. Feeling very full after eating only a little bit of a meal | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| 7. Bloating or distention (your abdomen feels swollen or gassy) | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| 8. Constipation | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| 9. Diarrhea | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |



| A. Complaints | | | | |
|---|----------------------------|-----------------------------|----------------------------|----------------------------|
| Complaint | Did not occur | Complaint occurred and was: | | |
| | | Mild | Moderate | Severe |
| 10. Abdominal pain below the navel | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| 11. Leg or arm pain during or following exercise | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| 12. Swollen or sore joints during or following exercise | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| 13. A pulled or strained muscle, tendon, or ligament during or following exercise | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| 14. Sores on your feet that heal poorly | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| 15. Swelling of the feet or ankles | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| 16. Chest pain/angina/heart pain | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| 17. Palpitations/Heart racing/Heart skipping beats | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| 18. Shortness of breath with exercise | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| 19. Shortness of breath lying down or waking you up at night | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| 20. Dizzy or lightheaded when you stand up | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| 21. Dizzy or lightheaded anytime | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| 22. Worsening of your eyesight | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| 23. Numbness or weakness of one arm or leg | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |



A. Complaints

24. Have you experienced low blood sugar in the last 3 months?

Yes →

How many times was your low blood sugar so severe that you had to be in the hospital? (number of times, "00" if none)

How many times was your low blood sugar so severe you had to visit the emergency room, but not be admitted to the hospital? (number of times, "00" if none)

How many times was your low blood sugar so severe that you needed someone to help you (but not ER visit or hospitalization)? (number of times, "00" if none)

How many times have you had low blood sugar in the last 7 days? (number of times, "00" if none)

Did any of these times occur without symptoms? Yes No

Did any of these times result in injury to yourself or to others? Yes No

Did any of these times occur when you were asleep? Yes No

No → Go to Section B, "Knees," next page

25. Was your blood sugar checked during the most severe episode of low blood sugar?

Yes →

What was the glucose value?

No

26. Has your medicine for diabetes been changed as a result of these episodes of low blood sugar?

Yes →

Who changed your diabetes medicines?
 Primary Care Physician
 Look AHEAD Personnel
 Other

No

B. Knees

Have you had any pain or discomfort in your knees in the past month?

- 1 Yes → CONTINUE
- 2 No → Go to Section C, "Urinary History"

1. Please mark an X on the scale for how bad the **pain** in your **right** knee has been in the past 2 weeks.



For office use only:

| | | |
|--|--|--|
| | | |
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2. Please mark an X on the scale for how bad the **pain** in your **left** knee has been in the past 2 weeks.



For office use only:

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| | | |
|--|--|--|

The following questions concern the amount of pain you have experienced in your knee(s). For each situation please enter the amount of pain experienced in the last 2 weeks.

QUESTION: How much pain do you have?

3. Walking on a flat surface.

- 1 None
- 2 Mild
- 3 Moderate
- 4 Severe
- 5 Extreme

4. Going up or down stairs.

- 1 None
- 2 Mild
- 3 Moderate
- 4 Severe
- 5 Extreme

5. At night while in bed.

- 1 None
- 2 Mild
- 3 Moderate
- 4 Severe
- 5 Extreme

6. Sitting or lying.

- 1 None
- 2 Mild
- 3 Moderate
- 4 Severe
- 5 Extreme

7. Standing upright.

- 1 None
- 2 Mild
- 3 Moderate
- 4 Severe
- 5 Extreme



B. Knees

The following questions concern the amount of joint stiffness (not pain) you have experienced in the last 2 weeks in your knee(s). Stiffness is a sensation of restriction or slowness in the ease with which you move your joints.

8. How **severe** is your stiffness **after first wakening** in the morning?

- 1 None 2 Mild 3 Moderate 4 Severe 5 Extreme

9. How **severe** is your stiffness after sitting, lying or resting **later in the day**?

- 1 None 2 Mild 3 Moderate 4 Severe 5 Extreme

The following questions concern your physical function. By this we mean your ability to move around and to look after yourself. For each of the following activities, please indicate the degree of difficulty you have experienced in the last 2 weeks due to arthritis, pain or discomfort in your knee(s).

QUESTION: What degree of difficulty do you have?

10. Descending stairs.

- 1 None 2 Mild 3 Moderate 4 Severe 5 Extreme

11. Ascending stairs.

- 1 None 2 Mild 3 Moderate 4 Severe 5 Extreme

12. Rising from sitting.

- 1 None 2 Mild 3 Moderate 4 Severe 5 Extreme

13. Standing.

- 1 None 2 Mild 3 Moderate 4 Severe 5 Extreme

14. Bending to floor.

- 1 None 2 Mild 3 Moderate 4 Severe 5 Extreme

15. Walking on flat.

- 1 None 2 Mild 3 Moderate 4 Severe 5 Extreme

16. Getting in/out of car.

- 1 None 2 Mild 3 Moderate 4 Severe 5 Extreme



B. Knees

17. Going shopping.

1 None 2 Mild 3 Moderate 4 Severe 5 Extreme

18. Putting on socks/stockings.

1 None 2 Mild 3 Moderate 4 Severe 5 Extreme

19. Rising from bed.

1 None 2 Mild 3 Moderate 4 Severe 5 Extreme

20. Taking off socks/stockings.

1 None 2 Mild 3 Moderate 4 Severe 5 Extreme

21. Lying in bed.

1 None 2 Mild 3 Moderate 4 Severe 5 Extreme

22. Getting in/out of bath.

1 None 2 Mild 3 Moderate 4 Severe 5 Extreme

23. Sitting.

1 None 2 Mild 3 Moderate 4 Severe 5 Extreme

24. Getting on/off toilet.

1 None 2 Mild 3 Moderate 4 Severe 5 Extreme

25. Heavy domestic duties.

1 None 2 Mild 3 Moderate 4 Severe 5 Extreme

26. Light domestic duties.

1 None 2 Mild 3 Moderate 4 Severe 5 Extreme



C. Urinary History

The following questions are about your urinary or bladder habits. These questions may seem personal or embarrassing, but your answers are important for research on these common health issues.

1. In the **past 12 months**, have you been told by a doctor that you had an infection of your bladder (urinary tract infection) or kidneys?

Yes →

a. Number of bladder (urinary tract) infections **in the last year**

No

b. Number of kidney infections **in the last year**

I don't know if it was an infection of my bladder or of my kidneys.

2. In the **past 7 days**, on average, how many times each day have you had **to go to the bathroom to urinate**:

a. during the day? **times per day**

b. during the night after going to bed? **times per night**

3. Many people complain that they leak urine or wet themselves accidentally. In the **past 12 months**, have you **leaked even a small amount of urine?** (*Check one only*)

None

Less than once per month

One or more times per month

One or more times per week

Every day

4. Have you leaked even a small amount of urine or wet yourself **in the past 7 days?**

Yes →

In the past 7 days, how many times did you leak urine with . . . (**Mark all that apply**)

No

a. An activity like coughing, sneezing, lifting, or exercise.

times in the **last week**

b. An urge to urinate and couldn't get to the bathroom fast enough.

times in the **last week**

c. Other reasons or don't know.

times in the **last week**



D. Weight History

- 1. How much did you weigh when you were 20 years old? pounds
- 2. How much did you weigh when you were 30 years old? pounds
- 3. How much did you weigh when you were 40 years old? pounds
- 4. How much did you weigh when you were 50 years old?
(Do not answer if you have not reached 50 years of age yet.) pounds
- 5. How much did you weigh when you were 60 years old?
(Do not answer if you have not reached 60 years of age yet.) pounds
- 6. How much did you weigh when you were 70 years old?
(Do not answer if you have not reached 70 years of age yet.) pounds
- 7. What is the most you have ever weighed, not counting pregnancies? pounds

8. Since you were 20 years old, how many different times did you lose each of the following amounts of weight **ON PURPOSE** (not including pregnancy or childbirth)?

Please check one box for each row, even if the answer is zero.

| | 0 times | 1-2 times | 3-4 times | 5-6 times | 7+ times |
|-----------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| a. 5-9 pounds | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| b. 10-19 pounds | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| c. 20-49 pounds | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| d. 50-79 pounds | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| e. 80-99 pounds | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| f. 100+ pounds | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |



D. Weight History

9. Since you were 20 years old, how many different times did you lose each of the following amounts of weight NOT ON PURPOSE (not including pregnancy or childbirth)?

Please check one box for each row, even if the answer is zero.

| | 0 times | 1-2 times | 3-4 times | 5-6 times | 7+ times |
|-----------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| a. 5-9 pounds | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| b. 10-19 pounds | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| c. 20-49 pounds | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| d. 50-79 pounds | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| e. 80-99 pounds | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| f. 100+ pounds | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |