

Site ID:    Subject ID:      
 Reviewed by (certification no.):

Enrollment year:  
 For coordinator use only. Review date:   /   /

**Teen-LABS (EF) Enrollment Form**

**Form completion date:**  /  / 20 (mm/dd/yyyy) **Completed by (certification no.):**

Please PRINT NEATLY and complete this form in blue or black INK. Mark response boxes like this:

1. Consent to Teen LABS:

No



Yes



1.1 Reason for refusing or not enrolling (*mark all that apply*):

- General lack of interest
- Does not want to be bothered; follow-up too burdensome
- Lack of trust (e.g., that personal information will remain confidential)
- Concerned that information provided will impact ability to have surgery
- No perceived personal benefit from participating
- Does not want to be included as subject in medical research
- Unable to communicate with study staff
- Less than 14 days notice to surgery
- Unable to schedule baseline visit
- Unable to contact prior to surgery
- Other *specify*: \_\_\_\_\_
- Unknown

1.2 Patient's age:   years

1.3 Date of consent:  
 /  /   
 (mm/dd/yyyy)

1.4 Patient's date of birth:  
 /   
 mm                  yyyy

1.5 Expected date of surgery:  
 /  /   
 (mm/dd/yyyy)

1.6 Consent version number:  
 \_\_\_\_\_

**To be completed on all patients who provide informed consent. Sites that have the proper IRB approval should also complete this section for all patients who decline to provide informed consent.**

2. Gender:  Male  Female

3. Height:     .   cm      3.1 How was height measured:  Standing  Lying flat  Estimate

3.2 If height was NOT measured standing, specify why not:

\_\_\_\_\_

4. Weight:     .   kg      4.1 How was weight measured:  
 Tanita Scale  Other Scale  Last available bed weight  Estimate

4.2 If weight was NOT measured with a Tanita Scale, specify why not:

\_\_\_\_\_

5. Ethnicity:  Hispanic  Non-Hispanic  Unknown

6. Race (*mark all that apply*):

- White or Caucasian
- Black or African-American
- Asian
- American Indian or Alaska Native
- Native Hawaiian or other Pacific Islander
- Other *specify*: \_\_\_\_\_
- Unknown

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Review date:  /  / 

## Teen-LABS (PO) Pre-Operative Form

Form completion date:  /  / 20 (mm/dd/yyyy) Completed by (certification no.): Please PRINT NEATLY and complete this form in blue or black INK. Mark response boxes like this: 

1. Previous obesity surgery OR surgery performed on the esophagus, stomach or proximal small intestine not for the purpose of weight loss?

 No  Yes

1.1 If yes, specify. (Mark "No" or "Yes" for each item.)

	No	Yes	Number of previous surgeries (including revisions and reversals)	Date of most recent surgery (mm/dd/yyyy -- enter as much as is known)
Gastric Bypass (Roux-en-Y)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Biliopancreatic div. (BPD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Biliopancreatic div. w/switch (BPDS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Adjustable Gastric Band (AGB)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Vertical Banded Gast. (VBG)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Sleeve Gastrectomy (SG)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Prior surgery performed on the esophagus, stomach, or proximal small intestine NOT for the purpose of weight loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Other previous obesity surgery 1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Specify: _____				
Other previous obesity surgery 2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Specify: _____				

2. Smoking status:

 Never smoked Current Former

Age started regularly:

Average packs/day:



Age started regularly:

Age quit:

Average packs/day:

Site ID:

Subject ID:

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### Teen-LABS (PO) Pre-Operative Form

3. Planned procedure:

- Gastric bypass (Roux-en-Y)
- Biliopancreatic diversion (BPD)
- Biliopancreatic diversion with Doudenal Switch (BPDS)
- Laparoscopic adjustable gastric band (LAGB)
- Sleeve gastrectomy - initial stage
- Sleeve gastrectomy - second stage →  Gastric bypass (Roux-en-Y)  BPD  BPDS
- Banded Gastric bypass (Gastric bypass & non-adjustable band)
- Vertical Banded Gastroplasty
- Other *specify*: \_\_\_\_\_
- Unknown at this time

4. Planned approach:

- Laparoscopic
- Open
- Unknown

5. Is the planned procedure a revision?

- No
- Yes → 

5.1 Patient status at time of previous procedure:  
 Teen LABS Registered patient  Non-Teen LABS patient

6. Is the planned procedure a reversal?

- No
- Yes → 

6.1 Patient status at time of previous procedure:  
 Teen LABS Registered patient  Non-Teen LABS patient

7. Medications in the past 90 days: (*Mark "No" or "Yes" for each item.*)

- | <u>No</u>                | <u>Yes</u>               |                                       |
|--------------------------|--------------------------|---------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Therapeutic oral/IV immunosuppressant |
| <input type="checkbox"/> | <input type="checkbox"/> | Therapeutic anticoagulation           |
| <input type="checkbox"/> | <input type="checkbox"/> | Narcotic                              |
| <input type="checkbox"/> | <input type="checkbox"/> | Statin or other lipid lowering agent  |
| <input type="checkbox"/> | <input type="checkbox"/> | Antidepressant                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Beta-blocker                          |

8. What is the patient's functional status?

- Can walk (length of grocery store aisle) 200ft unassisted
- Able to walk 200ft with assist device (cane, walker)
- Cannot walk 200ft with assist device
- Unknown

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### Teen-LABS (PO) Pre-Operative Form

9. Comorbidities: (Mark "No" or "Yes" to each.)

Comorbidity	No	Yes		If yes, mark the <u>one</u> best response		
a. Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="checkbox"/> No medication	<input type="checkbox"/> Single medication	<input type="checkbox"/> Multiple medications
b. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="checkbox"/> No medication	<input type="checkbox"/> Single oral medication	<input type="checkbox"/> Multiple oral medications
c. CHF	<input type="checkbox"/>	<input type="checkbox"/>	→	NYHC: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> Unknown		
d. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="checkbox"/> History of Intubation <input type="checkbox"/> No History of Intubation		

Comorbidity	No	Yes		If yes, mark "No" or "Yes" for each item	
e. History of DVT/PE	<input type="checkbox"/>	<input type="checkbox"/>	→	<u>No</u>	<u>Yes</u>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
f. Sleep apnea	<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
g. Ischemic Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>

Comorbidity	No	Yes
h. Pulmonary hypertension	<input type="checkbox"/>	<input type="checkbox"/>
i. History of venous edema with ulcerations	<input type="checkbox"/>	<input type="checkbox"/>
j. Pseudotumor Cerebri	<input type="checkbox"/>	<input type="checkbox"/>
k. Dyslipidemia	<input type="checkbox"/>	<input type="checkbox"/>
l. Intertriginous zone infection/breakdown	<input type="checkbox"/>	<input type="checkbox"/>
m. Gallstones	<input type="checkbox"/>	<input type="checkbox"/>
n. Acid reflux (heartburn)/GERD	<input type="checkbox"/>	<input type="checkbox"/>
o. Blount's Disease	<input type="checkbox"/>	<input type="checkbox"/>

10. Are there any comorbid conditions the patient may have that could affect clinical outcome following bariatric surgery?

No  Yes →

10.1 If yes, specify. (Limit one comorbidity per box.)


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### Teen-LABS (ANTH) Anthropometrics

Evaluation date:   /   /   (mm/dd/yyyy) Completed by (certification no.):

Time of evaluation:   :   (military format)

Last date/time patient had anything to eat or drink, including water: Date:   /   /   Time:   :   (military format)

Please PRINT NEATLY and complete this form in blue or black INK. Mark response boxes like this:

	Measurement 1	Measurement 2	Measurement 3	Was not assessed
<b>Height:</b>	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> cm	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> cm	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> cm	<input type="checkbox"/> Height
Measured:	<input type="checkbox"/> Standing <input type="checkbox"/> Lying flat* <input type="checkbox"/> Estimate*	<input type="checkbox"/> Standing <input type="checkbox"/> Lying flat* <input type="checkbox"/> Estimate*	<input type="checkbox"/> Standing <input type="checkbox"/> Lying flat* <input type="checkbox"/> Estimate*	

\*Specify why height wasn't measured standing:

	Measurement 1	Measurement 2	Measurement 3	Was not assessed
<b>Weight:</b>	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> kg	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> kg	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> kg	<input type="checkbox"/> Weight
Percent body fat:	<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"/> %	
Impedance:	<input type="text"/> <input type="text"/> <input type="text"/> Ω	<input type="text"/> <input type="text"/> <input type="text"/> Ω	<input type="text"/> <input type="text"/> <input type="text"/> Ω	
Weight measured:	<input type="checkbox"/> Tanita Scale <input type="checkbox"/> Other Scale* <input type="checkbox"/> Last available bed weight* <input type="checkbox"/> Estimate*	<input type="checkbox"/> Tanita Scale <input type="checkbox"/> Other Scale* <input type="checkbox"/> Last available bed weight* <input type="checkbox"/> Estimate*	<input type="checkbox"/> Tanita Scale <input type="checkbox"/> Other Scale* <input type="checkbox"/> Last available bed weight* <input type="checkbox"/> Estimate*	

\*Specify why weight wasn't measured with Tanita Scale:

<b>Midpoint waist circumference:</b>	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> cm	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> cm	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> cm	<input type="checkbox"/> Umbilical
<b>Iliac waist circumference:</b>	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> cm	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> cm	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> cm	<input type="checkbox"/> Iliac
<b>Sagittal abdominal diameter:</b>	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> cm	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> cm	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> cm	<input type="checkbox"/> Sagittal
<b>Neck circumference:</b>	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> cm	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> cm	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> cm	<input type="checkbox"/> Neck
<b>Resting heart rate:</b>	<input type="text"/> <input type="text"/> <input type="text"/> bpm	<input type="text"/> <input type="text"/> <input type="text"/> bpm	<input type="text"/> <input type="text"/> <input type="text"/> bpm	<input type="checkbox"/> Heart rate
<b>Blood pressure (systolic/diastolic):</b>	<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="checkbox"/> BP
Measured:	<input type="checkbox"/> Mercury <input type="checkbox"/> Gauge <input type="checkbox"/> Electronic	<input type="checkbox"/> Mercury <input type="checkbox"/> Gauge <input type="checkbox"/> Electronic	<input type="checkbox"/> Mercury <input type="checkbox"/> Gauge <input type="checkbox"/> Electronic	

**DEXA scan information** Mark here if DEXA was not performed:

Date of DEXA scan:   /   /   Percent body fat:   .   %

Total bone mineral content:     gm → Value in relation to reference range:  High  Within  Low

Total bone mineral density:   .    gm/cm<sup>2</sup> → Value in relation to reference range:  High  Within  Low

Site ID:    Subject ID:      
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**Teen-LABS (PTP) Prescribed Treatment Plan**

Form completion date:  /  / 20 (mm/dd/yyyy) Completed by (certification no.):

Please PRINT NEATLY and complete this form in blue or black INK. Mark response boxes like this:

For each supplement listed, specify whether or not it is prescribed. If it is, specify the type, dosing, and frequency, where indicated.

	<u>Prescribed?</u>		<u>Type</u>	<u>Dosing</u>	<u>Frequency</u>
	<u>No</u>	<u>Yes</u>			
1. Multivitamin	<input type="checkbox"/>	<input type="checkbox"/> →	<i>Specify:</i> <input type="checkbox"/> Centrum Chewables <input type="checkbox"/> Centrum <input type="checkbox"/> NataChew Prenatal w/Iron <input type="checkbox"/> Flintstone/Bugs Bunny/ Other Chewables <input type="checkbox"/> Generic Multivitamin (e.g., Grocery chain, Walmart) <input type="checkbox"/> Brand name multivitamin (e.g., One-A-Day) <input type="checkbox"/> Other, specify: <input type="text"/>	<input type="text"/> tablet(s)	<input type="text"/> times/day
2. B-Vitamins					
a. Vitamin B-1	<input type="checkbox"/>	<input type="checkbox"/> →	n/a →	<input type="text"/> mg	<input type="text"/> times/day
b. Vitamin B-50 complex	<input type="checkbox"/>	<input type="checkbox"/> →	n/a →	n/a →	<input type="text"/> times/day
c. Vitamin B-12	<input type="checkbox"/>	<input type="checkbox"/> →	n/a →	<input type="text"/> mcg	<input type="text"/> times/day
d. Vitamin B-12 shot	<input type="checkbox"/>	<input type="checkbox"/> →	n/a →	n/a →	<input type="checkbox"/> Monthly <input type="checkbox"/> Other, specify: <input type="text"/>
3. Calcium	<input type="checkbox"/>	<input type="checkbox"/> →	<i>Specify:</i> <input type="checkbox"/> Sugar-Free TUMS <input type="checkbox"/> Caltrate <input type="checkbox"/> Citracal + VitaminD <input type="checkbox"/> Oscal + Vitamin D <input type="checkbox"/> Viactiv Chewables <input type="checkbox"/> Other, specify: <input type="text"/>	<input type="text"/> mg	<input type="text"/> times/day
4. Vitamin D (alone)	<input type="checkbox"/>	<input type="checkbox"/> →	<i>Specify:</i> <input type="text"/>	<input type="text"/> I.U.	<input type="text"/> times/day
5. Iron	<input type="checkbox"/>	<input type="checkbox"/> →	<i>Specify:</i> <input type="checkbox"/> Feosol <input type="checkbox"/> Niferex <input type="checkbox"/> Other, specify: <input type="text"/>	<input type="text"/> mg	<input type="text"/> times/day



<b>Site ID:</b> <input style="width: 30px;" type="text"/>	<b>Subject ID:</b> <input style="width: 30px;" type="text"/>	<b>Reviewed by (certification no.):</b> <input style="width: 30px;" type="text"/>	
<b>Visit:</b> <input style="width: 30px;" type="text"/>	<b>For coordinator use only.</b>	<b>Review date:</b> <input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/>	

### Teen-LABS (MWF) 400 Meter Walk Data Collection Form

**Form completion date:**  /  / 20 (mm/dd/yyyy)    **Completed by (certification no.):**

Please PRINT NEATLY and complete this form in blue or black INK. Mark response boxes like this:

**READ:** We would like you to attempt to walk 400 meters (about ¼ mile) at your usual walking pace, as a measure of physical function. So that I can record your heart rate before, during and after the walk I'd like you to wear a Polar heart rate monitor. The monitor has two pieces. The first piece is placed under your shirt against your chest with a band. The second piece, which displays your heart rate, is worn like a wrist watch. Immediately before and after the walk I will measure your heart rate. I will also measure your resting heart rate 2 minutes after you have completed the walk. Therefore, after the walk I will ask you to please sit and rest for 2 minutes. May I put the heart rate monitor on you now?

*After putting the Polar Heart Rate Monitor on the participant, accompany the participant to the starting line and ask him or her to sit in the chair at the start while you explain the next section.*

During this walk, I will ask you to rate how hard you feel you are working while you continue walking. When I ask you to rate how hard you are working during the walk, I want you to think about the total feeling of exertion in your overall body, including your breathing and muscles.

Please note, as a safety precaution if your heart rate goes above 200 beats per minute at any time during the walk the heart rate monitor will beep and I will ask you to slow down. Please do not be alarmed, simply slow down. If your heart rate remains above 200 beats per minute for more than 5 minutes I will end the walk and ask that you sit and rest.

If, at any time during the test, you feel any chest pain, tightness or pressure in your chest, you become short of breath or if you feel faint, lightheaded or dizzy, or you feel knee, hip, calf, or back pain please tell me. If you feel any of these symptoms, you may slow down or rest. You may also choose to stop the walk.

Do you have any questions?

1. Resting heart rate before start of walk:   (bpm)

**READ:** When I say 'GO,' start walking at your **usual pace**. Ready, GO.

*Cross off as each lap is completed. If using short course, cross off half laps as well.*

	<b>1</b>		<b>2</b>		<b>3</b>		<b>4*</b>		<b>5</b>		<b>6</b>		<b>7</b>		<b>8*</b>		<b>9</b>		<b>10</b>
--	----------	--	----------	--	----------	--	-----------	--	----------	--	----------	--	----------	--	-----------	--	----------	--	-----------

*Offer participant encouragement after each 40 meter lap.*

**READ:** Good job (*or*: you are doing well, keep it up). You have completed \_\_\_ laps and have \_\_\_ to go.

*\*After the 4th and 8th lap, read the following question to the participant:*

**READ:** Please tell me how hard you feel you are working right now. Is it "light," "somewhat hard," "hard," or "very hard?"

2. Did the participant complete the 4th lap?

No     Yes    →

2.1 Response after the 4th lap:  
 Light     Somewhat hard     Hard\*\*     Very hard\*\*

3. Did the participant complete the 8th lap?

No     Yes    →

3.1 Response after the 8th lap:  
 Light     Somewhat hard     Hard\*\*     Very hard\*\*

*\*\*If the participant reports "hard" or "very hard:"*

**READ:** I would like to remind you to walk at your usual pace. If you develop chest pain or significant shortness of breath, or are too uncomfortable to continue, please stop walking and tell me. If you need to, you may stand in one place and rest.

Site ID: Subject ID: Visit: 

For coordinator use only.

## Teen-LABS (MWF) 400 Meter Walk Data Collection Form

4. Record the following information about rest stops. For each rest stop, record the length of time of the rest (*standing rests only*). After 30 seconds and again after 60 seconds, ask participant if he/she feels okay to continue walking.

Rest Stop	<30 sec	30 sec	31-59 sec	60 sec	>60 sec (test stopped)
1	<input type="checkbox"/>				
2	<input type="checkbox"/>				
3	<input type="checkbox"/>				
4	<input type="checkbox"/>				
5	<input type="checkbox"/>				
6	<input type="checkbox"/>				
7	<input type="checkbox"/>				
8	<input type="checkbox"/>				
9	<input type="checkbox"/>				
10	<input type="checkbox"/>				

5. Total number of rest stops:  rest stops

6. Did the participant complete all 10 laps (*short course: count each lap as half lap*)?

No  Yes



6.1 Number of laps completed (*short course: count each lap as half lap*):  .  laps

6.2 How many additional meters walked after the last fully completed lap?  .  meters

6.3 Why didn't the participant complete 400 meters (*specify "No" or "Yes" to each*)?

No Yes



Participant reported that they felt too tired

No Yes



Participant sat down during test



Reported chest pain, tightness, or pressure during test



Participant needed to rest for more than 60 seconds



Reported trouble breathing, or shortness of breath during test



Participant requested or needed cane or assistive device



Reported feeling faint, lightheaded, or dizzy during test



Participant heart rate was over 200 bpm for 5 minutes



Reported knee pain during test



More than 15 minutes elapsed from start of test



Reported hip pain during test



Participant refused



Reported calf pain during test



Other *specify below:*



Reported back pain during test

7. Time at 400-m or at stop:

:  :

*min. sec. hundredths/sec*

Site ID: Subject ID: Visit: 

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## Teen-LABS (MWF) 400 Meter Walk Data Collection Form

8. Heart rate at 400-m or at stop:  (bpm)9. Average heart rate at end of the walk:  (bpm) (record -2 "N/A" if heart rate was measured manually)10. Heart rate 2 minutes after stop:  (bpm)11. How was heart rate measured for this test?  Polar Heart Monitor  Manually

12. While you were walking, did you have any of the following symptoms:

	<u>No</u>	<u>Yes</u>	<u>Don't know</u>	<u>Refused</u>
12.1 Chest pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12.2 Shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12.3 Knee pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12.4 Hip pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12.5 Calf pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12.6 Foot pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12.7 Numbness or tingling in your legs or feet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12.8 Leg cramps?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12.9 Back pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12.10 Other <i>specify</i> :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

13. Are you having any discomfort now?

 No  Yes

*Note: If the participant develops, as a result of the corridor walk, chest pain or other symptoms listed below, the clinic supervisor should be notified immediately to determine whether or not medical attention is warranted. If the participant specifies an "other" symptom, it is up to the person administering the 400 meter walk to determine if a clinic supervisor should be notified to determine whether medical attention is needed. If uncertain, then the clinic supervisor should be notified. A "clinic supervisor" can be any person with medical training who has the **ability** to determine whether or not there is a need for medical attention prior to the participant leaving the research visit. "Medical attention" is defined as an intervention, prescription for physical therapy, prescription for or administration of medication, medical tests ordered, participant held for observation, etc., by a trained medical professional.*

	<u>No</u>	<u>Yes</u>
13.1 Chest pain, pressure	<input type="checkbox"/>	<input type="checkbox"/>
13.2 Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
13.3 Loss of consciousness or an acute or new-onset bout of 'dizziness' and/or 'lightheadedness'	<input type="checkbox"/>	<input type="checkbox"/>
13.4 Persistent severe lower extremity pain that does not resolve	<input type="checkbox"/>	<input type="checkbox"/>
13.5 Wheezing or dyspnea	<input type="checkbox"/>	<input type="checkbox"/>
13.6 Other <i>specify</i> :	<input type="checkbox"/>	<input type="checkbox"/>

Site ID:    Subject ID:

Reviewed by (certification no.):

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**Teen-LABS (RCAB) Research Coordinator Assessment Baseline**

Form completion date:  /  /  20  (mm/dd/yyyy) Completed by (certification no.):

Please PRINT NEATLY and complete this form in blue or black INK. Mark response boxes like this:

1. Clinical test(s) in preparation for bariatric surgery within 12 months. (Mark "No," "Yes," or "Unk" for each procedure. If completed, specify results.)

	No	Yes	Unk	If yes	Results																								
1.1 CAT scan of chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal																								
1.2 Stress test: <input type="checkbox"/> Exercise <input type="checkbox"/> Chemical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal																								
1.3 Right Heart Catherization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal																								
1.4 Left Heart Catherization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal																								
1.5 Cardiac function (Based on an echocardiogram, cardiac MRI, CT imaging, ventriculography, Gated SPECT, MUGA.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	→	LVEF: <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> % <i>enter "-3" if no percent available</i> If no percent available: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal LVMI: <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> g/m <sup>2.7</sup> LV mass: <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> gm Relative wall thickness: <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>																								
1.6 Endoscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	→	H. pylori: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not done Barret's Esophagus: <input type="checkbox"/> No <input type="checkbox"/> Yes Hiatal Hernia: <input type="checkbox"/> No <input type="checkbox"/> Yes																								
1.7 Upper GI series	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	→	Paraesophageal Hernia: <input type="checkbox"/> No <input type="checkbox"/> Yes Hiatal Hernia: <input type="checkbox"/> No <input type="checkbox"/> Yes																								
1.8 Pulseoximeter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	→	SAO <sub>2</sub> : <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> %																								
1.9 ECG	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	→	<table border="0"> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Normal</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>ST-T waves indicating possible ischemia</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Atrial Fib.</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Other, specify: _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Sinus Tach.</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Other Arrhythmia</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> </tr> </table>	<input type="checkbox"/>	<input type="checkbox"/>	Normal	<input type="checkbox"/>	<input type="checkbox"/>	ST-T waves indicating possible ischemia	<input type="checkbox"/>	<input type="checkbox"/>	Atrial Fib.	<input type="checkbox"/>	<input type="checkbox"/>	Other, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Tach.	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Other Arrhythmia	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Normal	<input type="checkbox"/>	<input type="checkbox"/>	ST-T waves indicating possible ischemia																								
<input type="checkbox"/>	<input type="checkbox"/>	Atrial Fib.	<input type="checkbox"/>	<input type="checkbox"/>	Other, specify: _____																								
<input type="checkbox"/>	<input type="checkbox"/>	Sinus Tach.	<input type="checkbox"/>	<input type="checkbox"/>																									
<input type="checkbox"/>	<input type="checkbox"/>	Other Arrhythmia	<input type="checkbox"/>	<input type="checkbox"/>																									
1.10 Polysomnogram	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	→	Apnea-Hypopnea Index (AHI): <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/>																								
1.11 Pulmonary Function Test (PFT)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	→	FEV1: <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> L % of defusing capacity: <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> FVC: <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> L																								
1.12 Arterial blood gas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	→	CO <sub>2</sub> : <input type="text"/> <input type="text"/> (mmHg) O <sub>2</sub> on room air temp: <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> (mmHg) O <sub>2</sub> on oxygen: <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> (mmHg)																								
1.13 Ultrasound gall bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	→	Evidence of gallstones: <input type="checkbox"/> No <input type="checkbox"/> Yes																								
1.14 Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	→	Results: _____																								

2. Pre-program height and weight (earliest weight after referral to surgical weight loss program):(enter "-3" if ht/wt unk or not available)

Height:    .  cm Weight:    .  kg Date height/weight obtained:   /   /

3. Is patient residing in a care facility (for example: personal care home, rehab facility, long-term care facility, assissted living)?

No  Yes

<b>Site ID:</b> <input type="text"/>	<b>Subject ID:</b> <input type="text"/>	<b>Reviewed by (certification no.):</b> <input type="text"/>	
<b>Visit:</b> <input type="text"/>	<b>For coordinator use only.</b>	<b>Review date:</b> <input type="text"/> / <input type="text"/> / <input type="text"/>	

**Teen-LABS (RCAF) Research Coordinator Assessment Follow-up**

**Form completion date:**  /  /  (mm/dd/yyyy)    **Completed by (certification no.):**

Please PRINT NEATLY and complete this form in blue or black INK. Mark response boxes like this:

**This form is used to capture clinical tests/procedures *since the patient's last study visit*. Note: if a participant missed their last visit, this will cover a longer time frame going back to the last visit they did have. In the case of multiple tests in that period, report the most recent results.**

1. Clinical test(s) *since patient's last study visit*. (Mark "No," "Yes," or "Unk" for each procedure. If completed, specify results.)

	<u>No</u>	<u>Yes</u>	<u>Unk</u>	<u>If yes</u>	<u>Results</u>
1.1 Cardiac function <small>(Based on an echocardiogram, cardiac MRI, CT imaging, ventriculography, Gated SPECT, MUGA.)</small>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	→	LVEF: <input type="text"/> . <input type="text"/> % <small>enter "-3" if no percent available</small> If no percent available: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal LVMI: <input type="text"/> . <input type="text"/> g/m <sup>2.7</sup> LV mass: <input type="text"/> . <input type="text"/> gm Relative wall thickness: <input type="text"/> . <input type="text"/>
1.2 Polysomnogram	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	→	Apnea-Hypopnea Index (AHI): <input type="text"/> . <input type="text"/>
1.3 Ultrasound gall bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	→	Evidence of gallstones: <input type="checkbox"/> No <input type="checkbox"/> Yes
1.4 Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	→	Results: _____

2. *Since the patient's last study visit*, has the patient been **hospitalized**?

No

Yes → If YES, complete a Health Care Utilization Form for each hospitalization.

3. *Since the patient's last study visit*, has the patient had any **out-patient procedures**?

No

Yes → If YES, complete a Health Care Utilization Form for each out-patient procedure.

4. *Since the patient's last study visit*, has the patient resided in a care facility (for example: personal care home, rehab facility, long-term care facility, assisted living)?

No

Yes

5. Is the patient: female AND at least 18 years old AND this is the 60 month (5 year) or 96 month (8 year) follow up visit?

No

Yes → 
 5.1 If YES, How many times has the patient been pregnant since having bariatric surgery. Count all pregnancies regardless of outcome (miscarriage, ectopic or tubal pregnancy, abortion, still birth, or live birth).  
 pregnancies  
*For each pregnancy, complete a Reproductive Health Pregnancy Questionnaire.*

Site ID: <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/>	Subject ID: <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/>	Reviewed by (certification no.): <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/>	Visit: <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/>	<b>For coordinator use only.</b>	Review date: <input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/>
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### Teen-LABS (LV) Lab Values: Most recent value within past 180 days

Form completion date:  /  /  20  (mm/dd/yyyy) Completed by (certification no.):

Please PRINT NEATLY and complete this form in blue or black INK. Mark response boxes like this:

VALUE IN RELATION TO REFERENCE RANGE

<u>BLOOD SAMPLES</u>	<u>BLOOD DRAW DATE</u> (MM/DD/YY)	<u>LAB VALUE</u>	HIGH	WITHIN	LOW	NOT DONE
Albumin:	<input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/> . <input style="width: 30px;" type="text"/> g/dl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
AST(SGOT):	<input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/> IU/L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ALT (SGPT):	<input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/> IU/L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alkaline Phosphatase:	<input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/> IU/L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Platelet:	<input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/> . <input style="width: 30px;" type="text"/> 10 <sup>3</sup> /mm <sup>3</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Total Cholesterol:	<input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/> mg/dl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HDL:	<input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/> mg/dl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LDL:	<input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/> mg/dl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Triglycerides:	<input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/> mg/dl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CRP:	<input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/> . <input style="width: 30px;" type="text"/> μM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OGTT glucose baseline:	<input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/> mg/dl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OGTT glucose 1 hour:	<input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/> mg/dl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OGTT glucose 2 hours:	<input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/> mg/dl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fasting Insulin:	<input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/> . <input style="width: 30px;" type="text"/> μU/ml	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HbA1C:	<input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/> . <input style="width: 30px;" type="text"/> %	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Normal HbA1C high range:	<input style="width: 30px;" type="text"/> . <input style="width: 30px;" type="text"/> %					

Site ID: Subject ID: Visit: 

For coordinator use only.

## Teen-LABS (LV) Lab Values: Most recent value within past 180 days

VALUE IN RELATION TO  
REFERENCE RANGE

<u>BLOOD SAMPLES</u>	<u>BLOOD DRAW DATE</u> (MM/DD/YY)	<u>LAB VALUE</u>	VALUE IN RELATION TO REFERENCE RANGE			
			HIGH	WITHIN	LOW	NOT DONE
Uric acid:	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> . <input type="text"/> mg/dl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Iron:	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> mcg/dl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ferritin:	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> ng/ml	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
WBC:	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> . <input type="text"/> k/ul	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hematocrit:	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> . <input type="text"/> %	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Total Bilirubin:	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> . <input type="text"/> mg/dl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lymphocytes:	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> . <input type="text"/> %	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
VitB1: <input type="checkbox"/> WB <input type="checkbox"/> serum	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> . <input type="text"/> ug/dl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Folate: <input type="checkbox"/> WB <input type="checkbox"/> serum	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> . <input type="text"/> ng/ml	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Homocysteine:	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> . <input type="text"/> μM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K:	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> . <input type="text"/> mEq/L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Creatinine:	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> . <input type="text"/> mg/dl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fasting Glucose:	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> mg/dl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Non-esterified fatty acids:	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> . <input type="text"/> mg/dl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PTH:	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> pg/ml	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Calcium:	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> . <input type="text"/> mg/dl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vitamin D:	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> . <input type="text"/> ng/ml	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vit B12:	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> . <input type="text"/> pg/ml	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>URINE SAMPLES</u>	<u>COLLECTION DATE</u>	<u>LAB VALUE</u>				
Albumin:	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> . <input type="text"/> mg/dl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Creatinine:	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> . <input type="text"/> mg/dl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Teen-LABS (POUF) Pre-Operative Update Form

Evaluation date:  /  / 20 (mm/dd/yyyy) Completed by (certification no.):

Consent date:  /  / 20 (mm/dd/yyyy)

Please PRINT NEATLY and complete this form in blue or black INK. Mark response boxes like this:

**INSTRUCTIONS:** If surgery is scheduled to occur 31 to 90 days after the baseline battery was completed, then this form should be completed along with other Visit 2 forms.

1. Smoking status:  Never smoked     Current     Former

↓

Age started regularly:

Average packs/day:  .

↓

Age started regularly:

Age quit:

Average packs/day:  .

2. Planned procedure:  Gastric bypass (Roux-en-Y)

Biliopancreatic diversion (BPD)

Biliopancreatic diversion with Doudenal Switch (BPDS)

Laparoscopic adjustable gastric band (LAGB)

Sleeve gastrectomy - initial stage

Sleeve gastrectomy - second stage →  Gastric bypass (Roux-en-Y)     BPD     BPDS

Banded Gastric bypass (Gastric bypass & non-adjustable band)

Vertical Banded Gastroplasty

Other *specify:* \_\_\_\_\_

Unknown at this time

3. Planned approach:  Laparoscopic     Open     Unknown

4. Is the planned procedure a revision?  No     Yes

5. Is the planned procedure a reversal?  No     Yes

6. Medications in the past 90 days: (Mark "No" or "Yes" for each item.)

No	Yes	
<input type="checkbox"/>	<input type="checkbox"/>	Therapeutic oral/IV immunosuppressant
<input type="checkbox"/>	<input type="checkbox"/>	Therapeutic anticoagulation
<input type="checkbox"/>	<input type="checkbox"/>	Narcotic
<input type="checkbox"/>	<input type="checkbox"/>	Statin or other lipid lowering agent
<input type="checkbox"/>	<input type="checkbox"/>	Antidepressant
<input type="checkbox"/>	<input type="checkbox"/>	Beta-blocker

7. What is the patient's functional status?  Can walk (length of grocery store aisle) 200ft unassisted     Able to walk 200 ft with assist device (cane, walker)     Cannot walk 200 ft with assist device     Unknown

Site ID:

Subject ID:

For coordinator use only.

**Teen-LABS (POUF) Pre-Operative Update Form**

8. Comorbidities (Mark "No" or "Yes" for each.)

Comorbidity	No	Yes		If yes, mark the <u>one</u> best response		
a. Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="checkbox"/> No medication	<input type="checkbox"/> Single medication	<input type="checkbox"/> Multiple medications
b. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="checkbox"/> No medication	<input type="checkbox"/> Single oral medication	<input type="checkbox"/> Multiple oral medications
c. CHF	<input type="checkbox"/>	<input type="checkbox"/>	→	NYHC: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> Unknown		
d. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="checkbox"/> History of Intubation <input type="checkbox"/> No History of Intubation		

Comorbidity	No	Yes		If yes, mark "No" or "Yes" for each item	
e. History of DVT/PE	<input type="checkbox"/>	<input type="checkbox"/>	→	<u>No</u>	<u>Yes</u>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
f. Sleep apnea	<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
g. Ischemic Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>

Comorbidity	No	Yes
h. Pulmonary hypertension	<input type="checkbox"/>	<input type="checkbox"/>
i. History of venous edema with ulcerations	<input type="checkbox"/>	<input type="checkbox"/>
j. Pseudotumor Cerebri	<input type="checkbox"/>	<input type="checkbox"/>
k. Dyslipidemia	<input type="checkbox"/>	<input type="checkbox"/>
l. Intertriginous zone infection/breakdown	<input type="checkbox"/>	<input type="checkbox"/>
m. Gallstones	<input type="checkbox"/>	<input type="checkbox"/>
n. Acid reflux (heartburn)/GERD	<input type="checkbox"/>	<input type="checkbox"/>
o. Blount's Disease	<input type="checkbox"/>	<input type="checkbox"/>

9. Are there any comorbid conditions the patient may have that could affect clinical outcome following bariatric surgery?

No  Yes →

9.1 If yes, specify. (Limit one comorbidity per box.)


	Site ID: <input type="text"/>	Subject ID: <input type="text"/>	Reviewed by (certification no.): <input type="text"/>	
Visit: <input type="text"/>	<b>For coordinator use only.</b>		Review date: <input type="text"/> / <input type="text"/> / <input type="text"/>	

### Teen-LABS (CAB) Comorbidity Assessment Baseline

**Form completion date:**  /  / 20 (mm/dd/yyyy)    **Completed by (certification no.):**

Please PRINT NEATLY and complete this form in blue or black INK. Mark response boxes like this:

**Assess the patient's health status; consider a 6 month time frame prior to the Teen-LABS baseline visit date when characterizing the patient. DO NOT assess historical events/comorbidities with these elements.**

*Characterize the patient over the past 6 months... (Select only one response per item unless noted otherwise.)*

1. Hypertension:

- No BP elevation diagnosed
- Hypertension, no pharmacologic treatment
- Hypertension, treatment with single medication
- Hypertension, treatment with two or more medications

2. Ischemic heart disease:

- No ischemic heart disease
- Abnormal ECG, no active angina
- Uses anti-ischemic medication, no angina
- Active angina (with or without medications or revascularization)

3. Peripheral Vascular Disease:

- No symptoms of peripheral vascular disease
- Bruit or diminished peripheral pulse(s), asymptomatic
- Claudication or extremity pain at rest
- Transient ischemic attack, anti-ischemic medication

4. Peripheral Edema:

None

Present →

4.1 Specify treatment(s) patient was using. (Mark "No" or "Yes" for each item.)

<u>No</u>	<u>Yes</u>		<u>No</u>	<u>Yes</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Support hose	<input type="checkbox"/>	<input type="checkbox"/>	Elevation of the legs
<input type="checkbox"/>	<input type="checkbox"/>	Diuretic	<input type="checkbox"/>	<input type="checkbox"/>	Unna boots
<input type="checkbox"/>	<input type="checkbox"/>	Blood thinners	<input type="checkbox"/>	<input type="checkbox"/>	Sequential compression boots
			<input type="checkbox"/>	<input type="checkbox"/>	Other <i>specify:</i> _____

4.2 PE confined to:

Pedal/ankle     Mid calf     High calf

Site ID:

Subject ID:

For coordinator use only.

## Teen-LABS (CAB) Comorbidity Assessment Baseline

*Characterize the patient over the past 6 months... (Select only one response per item unless noted otherwise.)*

5. Dyslipidemia:

- Not present
- No pharmacologic treatment for dyslipidemia
- Treatment with single medication for dyslipidemia
- Treatment with two or more medications for dyslipidemia

6. Abnormal glucose metabolism

*NOTE: Answer the following five items based on fasting blood glucose test and/or OGTT done within the past 6 months. If there was no test done in the past 6 months, mark "Test not done."*

a. Biochemical evidence of impaired fasting glucose (100-125 mg/dL):

- No
- Yes
- Test not done

b. Biochemical evidence of impaired glucose tolerance by OGTT (2 hour glucose 140-199 mg/dL):

- No
- Yes
- Test not done

c. Biochemical evidence of Diabetes Mellitus by OGTT (2 hour glucose  $\geq$ 200 mg/dL):

- No
- Yes
- Test not done

d. Biochemical evidence of Diabetes Mellitus by fasting glucose ( $>$ 125 mg/dL):

- No
- Yes
- Test not done

e. Does patient have postprandial hypoglycemia (glucose  $<$ 75 mg/dL):

- No
- Yes
- Suspected, not documented
- Test not done

7. Medications prescribed for abnormal glucose metabolism:

- No medication
- Single oral medication
- Multiple oral medications
- Insulin/non-insulin injectible
- Oral medications and insulin/non-insulin injectible

8. Thyroid:

- No hypothyroidism
- Hypothyroidism
- Hypothyroidism, treatment with medication

Site ID:

Subject ID:

For coordinator use only.

### Teen-LABS (CAB) Comorbidity Assessment Baseline

Characterize the patient over the past 6 months... (Select only one response per item unless noted otherwise.)

9. Diagnosed Sleep Apnea:

No

Yes →

9.1 Was the patient using C-PAP/Bi-PAP?  No  Yes → *If yes, frequency of use:*

Rarely (less than once per week)

Sometimes (about 3 times per week)

Often (about every day)

Always (I use it every time I sleep)

10. Asthma

a. Symptoms and non-steroid medication use:

No diagnosis or symptoms (wheezing, coughing) of asthma

Intermittent or mild symptoms, no medication

Symptoms present, non-steroid medication used less than monthly

Symptoms present, non-steroid medication used monthly but less than weekly

Symptoms present, non-steroid medication used weekly but less than daily

Symptoms present, non-steroid medication used daily

Symptoms persist with non-steroid medication

b. Has the patient been treated for asthma with enteral or parenteral steroids **within the past year?**

No

Yes

11. GERD:

a. Has there been any formal diagnostic testing for GERD **in the past 6 months?**

No

Yes →

11a.1 Test results:  Positive  Negative

b. Does the patient have symptoms of GERD:

No symptoms of GERD (heartburn, regurgitation, reflux)

Intermittent or variable symptoms, taking no medication

Intermittent medication use, including over the counter medications

H2 blockers used daily

Proton pump inhibitor used daily

Continued symptoms despite regular use of medications

Site ID:

Subject ID:

For coordinator use only.

### Teen-LABS (CAB) Comorbidity Assessment Baseline

*Characterize the patient over the past 6 months... (Select only one response per item unless noted otherwise.)*

12. Cholelithiasis:

- No diagnosis or symptoms of gallstones
- No diagnosis, symptoms present
- Documented gallstones with less than monthly symptoms
- Documented gallstones with weekly or monthly symptoms
- Documented gallstones with daily symptoms
- Documented complications of gallstones (e.g., pancreatitis)
- History of cholecystectomy

13. Nonalcoholic Fatty Liver Disease (*mark all that apply*):

- No diagnosis or evidence of NAFLD (normal AST, ALT, GGT)
- Abnormal serum aminotransferases (ALT, AST, or GGT)
- Imaging suggesting steatosis
- Biopsy confirmed hepatic steatosis
- Biopsy confirmed steatohepatitis → 

13.1 Specify: <input type="checkbox"/> with fibrosis <input type="checkbox"/> without fibrosis
--
- Biopsy confirmed cirrhosis, compensated
- Decompensated cirrhosis (end-stage liver disease with synthetic dysfunction)

14. Joint pain/deformity (*mark all that apply*):

- No symptoms of leg or joint pain
- Pain with ambulation once a week or less
- Pain with ambulation more than once a week
- Non-narcotic analgesia used regularly (weekly or monthly)
- Non-narcotic analgesia used frequently (more than once a week)
- Narcotic analgesia used regularly (weekly or monthly)
- Narcotic analgesia used frequently (more than once a week)

15. Back pain (*mark all that apply*):

- No symptoms of back pain
- Intermittent back pain, not requiring medication or treatment
- Non-narcotic analgesia used regularly (weekly or monthly)
- Non-narcotic analgesia used frequently (more than once per week)
- Narcotic analgesia used regularly (weekly or monthly)
- Narcotic analgesia used frequently (more than once per week)

Site ID:

Subject ID:

For coordinator use only.

## Teen-LABS (CAB) Comorbidity Assessment Baseline

*Characterize the patient over the past 6 months... (Select only one response per item unless noted otherwise.)*

### 16. Stress Urinary Incontinence:

- No diagnosis or symptoms of stress urinary incontinence
- Minimal, intermittent symptoms (less than monthly)
- Monthly symptoms (once or more each month)
- Weekly symptoms (once or more each week)
- Daily symptoms (once or more each day)

### 17. Menstrual Irregularities (*mark all that apply*):

- N/A, patient is male
- None
- Irregular menses or oligomenorrhea (>45 days)
- History of irregular menses or oligomenorrhea but now on contraceptives
- Menorrhagia requiring medical therapy
- Amenorrhea (>90 days)

### 18. Polycystic Ovarian Syndrome

- N/A, patient is male
- No diagnosis or symptoms of PCOS (hirsutism/moderate acne, oligo or amenorrhea)
- Symptoms of PCOS present, but no confirmed diagnosis or treatment
- Symptoms of PCOS present, treatment with contraceptive or anti-androgens
- Confirmed PCOS, no treatment
- Confirmed PCOS, treatment with contraceptive or anti-androgens
- Confirmed PCOS, treatment with metformin
- Combination treatment (contraceptives, anti-androgens, metformin)

### 19. Pseudotumor cerebri (*mark all that apply*):

- No diagnosis
- Headaches with no associated symptoms
  - ↳ 19.1 Frequency:  Daily  Weekly  Monthly
- Headaches with dizziness, nausea, or retro-orbital pain
  - ↳ 19.2 Frequency:  Daily  Weekly  Monthly
- Headaches with visual changes
  - ↳ 19.3 Frequency:  Daily  Weekly  Monthly
- Confirmed PTC, no medications
- Confirmed PTC, medications used (e.g., diuretics)
- CSF drainage required
- Persistent symptoms despite medications or drainage

Site ID:

Subject ID:

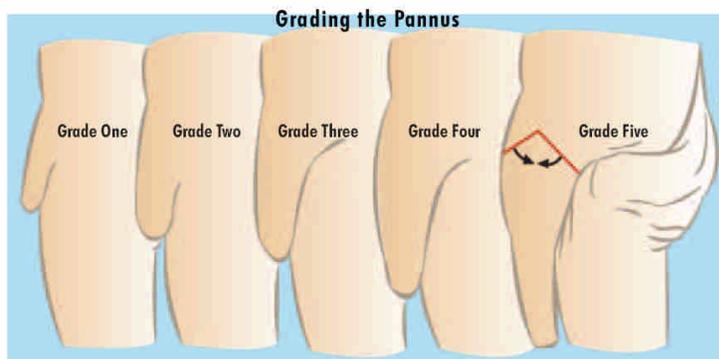
For coordinator use only.

### Teen-LABS (CAB) Comorbidity Assessment Baseline

Characterize the patient over the past 6 months... (Select only one response per item unless noted otherwise.)

20. Abdominal Pannus: anatomically characterize the pannus.

- Pannus less significant than Grade 1
- Grade 1. Pannus apron reaches hairline and mons pubis, but not the private areas.
- Grade 2. Pannus apron reaches private areas level with the upper thigh crease.
- Grade 3. Pannus apron reaches upper thigh.
- Grade 4. Pannus apron reaches mid thigh.
- Grade 5. Pannus apron reaches knees.



Grade One: Apron covers the pubic hairline. Grade Two: Apron covers the genitals in line with the upper thigh crease. Grade Three: Apron covers the upper thigh. Grade Four: Apron covers the mid thigh. Grade Five: Apron covers the knees or beyond.

21. Abdominal Pannus: dysfunction.

No symptoms

Symptomatic →

Mark "No" or "Yes" to each.

No	Yes	
<input type="checkbox"/>	<input type="checkbox"/>	Intertiginous/fungal cutaneous infection
<input type="checkbox"/>	<input type="checkbox"/>	Recurrent cellulitis
<input type="checkbox"/>	<input type="checkbox"/>	Superficial cutaneous ulceration
<input type="checkbox"/>	<input type="checkbox"/>	Deep ulceration/persistent drainage
<input type="checkbox"/>	<input type="checkbox"/>	Necrotizing fasciitis or surgical treatment required
<input type="checkbox"/>	<input type="checkbox"/>	Lymphedema of the pannus



22. Functional status:

- Patient is able to walk, most or all of the time
- Patient can not walk due to excessive weight
- Patient can not walk due to other health related issues

	Site ID: <input type="text"/>	Subject ID: <input type="text"/>	Reviewed by (certification no.): <input type="text"/>	
	Visit: <input type="text"/>	<b>For coordinator use only.</b>	Review date: <input type="text"/> / <input type="text"/> / <input type="text"/>	

**Teen-LABS (CAF) Comorbidity Assessment Follow-up**

**Form completion date:**  /  / 20 (mm/dd/yyyy)    **Completed by (certification no.):**

Please PRINT NEATLY and complete this form in blue or black INK. Mark response boxes like this:

**Assess the patient's current status at Teen-LABS follow-up visit; consider a two week time frame prior to the visit date when characterizing the patient. DO NOT assess historical events/comorbidities with these elements.**

*Characterize the patient's current status... (Select only one response per item unless noted otherwise.)*

1. Hypertension:
  - No BP elevation diagnosed
  - Hypertension, no pharmacologic treatment
  - Hypertension, treatment with single medication
  - Hypertension, treatment with two or more medications
  
2. Ischemic heart disease:
  - No ischemic heart disease
  - Currently has abnormal ECG, no active angina
  - Currently using anti-ischemic medication, no angina
  - Active angina (with or without medications or revascularization)
  
3. Peripheral Vascular Disease:
  - No current symptoms of peripheral vascular disease
  - Bruit or diminished peripheral pulse(s), asymptomatic
  - Claudication or current extremity pain at rest
  - Current transient ischemic attack, anti-ischemic medication

4. Peripheral Edema:

None

Present →

4.1 Specify treatment(s) patient uses. (Mark "No" or "Yes" for each item.)

<u>No</u>	<u>Yes</u>		<u>No</u>	<u>Yes</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Support hose	<input type="checkbox"/>	<input type="checkbox"/>	Elevation of the legs
<input type="checkbox"/>	<input type="checkbox"/>	Diuretic	<input type="checkbox"/>	<input type="checkbox"/>	Unna boots
<input type="checkbox"/>	<input type="checkbox"/>	Blood thinners	<input type="checkbox"/>	<input type="checkbox"/>	Sequential compression boots
			<input type="checkbox"/>	<input type="checkbox"/>	Other <i>specify:</i> _____

4.2 PE confined to:

Pedal/ankle     Mid calf     High calf

Site ID:

Subject ID:

Visit:

For coordinator use only.

### Teen-LABS (CAF) Comorbidity Assessment Follow-up

Characterize the patient's current status... (Select only one response per item unless noted otherwise.)

5. Dyslipidemia:

- Not present
- No pharmacologic treatment for dyslipidemia
- Treatment with single medication for dyslipidemia
- Treatment with two or more medications for dyslipidemia

6. Abnormal glucose metabolism

*NOTE: Answer the following five items based on fasting blood glucose test and/or OGTT done within the past two weeks. If there was no test done in the past two weeks, mark "Test not done."*

a. Biochemical evidence of impaired fasting glucose (100-125 mg/dL):

- No
- Yes
- Test not done within two weeks prior to visit

b. Biochemical evidence of impaired glucose tolerance by OGTT (2 hour glucose 140-199 mg/dL):

- No
- Yes
- Test not done within two weeks prior to visit

c. Biochemical evidence of Diabetes Mellitus by OGTT (2 hour glucose  $\geq$ 200 mg/dL):

- No
- Yes
- Test not done within two weeks prior to visit

d. Biochemical evidence of Diabetes Mellitus by fasting glucose ( $>$ 125 mg/dL):

- No
- Yes
- Test not done

e. Does patient have postprandial hypoglycemia (glucose  $<$ 75 mg/dL):

- No
- Yes
- Suspected, not documented
- Test not done

7. Medications prescribed for abnormal glucose metabolism:

- No medication
- Single oral medication
- Multiple oral medications
- Insulin/non-insulin injectible
- Oral medications and insulin/non-insulin injectible

8. Thyroid:

- No hypothyroidism
- Hypothyroidism
- Hypothyroidism, treatment with medication

Site ID:

Subject ID:

Visit:

For coordinator use only.

### Teen-LABS (CAF) Comorbidity Assessment Follow-up

Characterize the patient's current status... (Select only one response per item unless noted otherwise.)

9. Asthma:

a. Symptoms and non-steroid medication use:

- No diagnosis or symptoms (wheezing, coughing) of asthma
- Intermittent or mild symptoms, no medication
- Symptoms present, non-steroid medication used less than monthly
- Symptoms present, non-steroid medication used monthly but less than weekly
- Symptoms present, non-steroid medication used weekly but less than daily
- Symptoms present, non-steroid medication used daily
- Symptoms persist with non-steroid medication

b. Has the patient been treated for asthma with enteral or parenteral steroids since last study visit?

- No
- Yes

10. GERD:

a. Has there been any formal diagnostic testing for GERD since last study visit?

- No
- Yes → 

10a.1 Test results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative
---

b. Does the patient have symptoms of GERD:

- No symptoms of GERD (heartburn, regurgitation, reflux)
- Intermittent or variable symptoms, taking no medication
- Intermittent medication use, including over the counter medications
- H2 blockers used daily
- Proton pump inhibitor used daily
- Continued symptoms despite regular use of medications

11. Cholelithiasis:

- No diagnosis or symptoms of gallstones
- No diagnosis, symptoms present
- Documented gallstones with less than monthly symptoms
- Documented gallstones with weekly or monthly symptoms
- Documented gallstones with daily symptoms
- Documented complications of gallstones (e.g., pancreatitis)
- History of cholecystectomy

Site ID:

Subject ID:

Visit:

For coordinator use only.

### Teen-LABS (CAF) Comorbidity Assessment Follow-up

Characterize the patient's current status... (Select only one response per item unless noted otherwise.)

12. Nonalcoholic Fatty Liver Disease (mark all that apply): (Interim means "since the last study visit.")

- Normal AST, ALT, GGT
- History of NAFLD/NASH, no follow up biopsy done
- Abnormal serum aminotransferases (ALT, AST, or GGT)
- Interim imaging suggesting steatosis
- Interim biopsy confirmed hepatic steatosis
- Interim biopsy confirmed steatohepatitis → 

12.1 Specify: <input type="checkbox"/> with fibrosis <input type="checkbox"/> without fibrosis
--
- Interim biopsy confirmed cirrhosis, compensated
- Decompensated cirrhosis (end-stage liver disease with synthetic dysfunction)

13. Joint pain/deformity (mark all that apply):

- No symptoms of leg or joint pain
- Pain with ambulation once a week or less
- Pain with ambulation more than once a week
- Non-narcotic analgesia used regularly (weekly or monthly)
- Non-narcotic analgesia used frequently (more than once a week)
- Narcotic analgesia used regularly (weekly or monthly)
- Narcotic analgesia used frequently (more than once a week)

14. Back pain (mark all that apply):

- No symptoms of back pain
- Intermittent back pain, not requiring medication or treatment
- Non-narcotic analgesia used regularly (weekly or monthly)
- Non-narcotic analgesia used frequently (more than once per week)
- Narcotic analgesia used regularly (weekly or monthly)
- Narcotic analgesia used frequently (more than once per week)

15. Stress Urinary Incontinence:

- No diagnosis or symptoms of stress urinary incontinence
- Minimal, intermittent symptoms (less than monthly)
- Monthly symptoms (once or more each month)
- Weekly symptoms (once or more each week)
- Daily symptoms (once or more each day)

Site ID:

Subject ID:

Visit:

For coordinator use only.

### Teen-LABS (CAF) Comorbidity Assessment Follow-up

Characterize the patient's current status... (Select only one response per item unless noted otherwise.)

16. Menstrual Irregularities (mark all that apply):

- N/A, patient is male
- None
- Irregular menses or oligomenorrhea (>45 days)
- History of irregular menses or oligomenorrhea but now on contraceptives
- Menorrhagia requiring medical therapy
- Amenorrhea (>90 days)

17. Polycystic Ovarian Syndrome

- N/A, patient is male
- No diagnosis or symptoms of PCOS (hirsutism/moderate acne, oligo or amenorrhea)
- Symptoms of PCOS present, but no confirmed diagnosis or treatment
- Symptoms of PCOS present, treatment with contraceptive or anti-androgens
- Confirmed PCOS, no treatment
- Confirmed PCOS, treatment with contraceptive or anti-androgens
- Confirmed PCOS, treatment with metformin
- Combination treatment (contraceptives, anti-androgens, metformin)

18. Pseudotumor cerebri (mark all that apply): (Interim means "since the last study visit.")

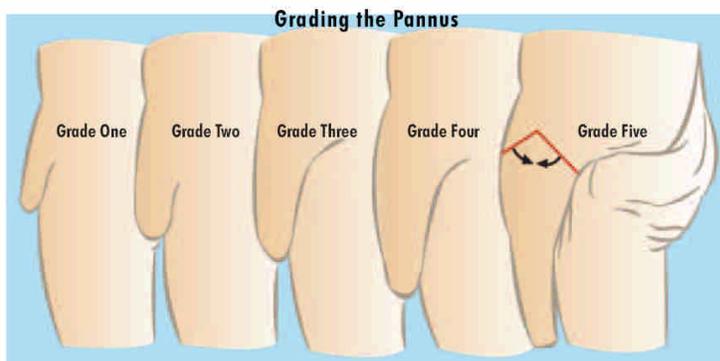
- No diagnosis
- Headaches with no associated symptoms
  - ↳ 18.1 Frequency:  Daily  Weekly  Monthly
- Headaches with dizziness, nausea, or retro-orbital pain
  - ↳ 18.2 Frequency:  Daily  Weekly  Monthly
- Headaches with visual changes
  - ↳ 18.3 Frequency:  Daily  Weekly  Monthly
- Confirmed PTC, no medication
- Confirmed PTC, medications used (e.g., diuretics)
- Interim CSF drainage required
- Persistent symptoms despite medications or drainage

### Teen-LABS (CAF) Comorbidity Assessment Follow-up

Characterize the patient's current status... (Select only one response per item unless noted otherwise.)

19. Abdominal Pannus: anatomically characterize the pannus.

- Pannus less significant than Grade 1
- Grade 1. Pannus apron reaches hairline and mons pubis, but not the private areas.
- Grade 2. Pannus apron reaches private areas level with the upper thigh crease.
- Grade 3. Pannus apron reaches upper thigh.
- Grade 4. Pannus apron reaches mid thigh.
- Grade 5. Pannus apron reaches knees.



Grade One: Apron covers the pubic hairline. Grade Two: Apron covers the genitals in line with the upper thigh crease. Grade Three: Apron covers the upper thigh. Grade Four: Apron covers the mid thigh. Grade Five: Apron covers the knees or beyond.

20. Abdominal Pannus: dysfunction.

- No symptoms
- Symptomatic →

<i>Mark "No" or "Yes" to each.</i>	
<u>No</u>	<u>Yes</u>
<input type="checkbox"/>	<input type="checkbox"/>

21. Functional status:

- Patient is able to walk, most or all of the time
- Patient can not walk due to excessive weight
- Patient can not walk due to other health related issues

<b>Site ID:</b> <input type="text"/>	<b>Subject ID:</b> <input type="text"/>	<b>Reviewed by (certification no.):</b> <input type="text"/>	
<b>Visit:</b> <input type="text"/>	<b>For coordinator use only.</b>	<b>Review date:</b> <input type="text"/> / <input type="text"/> / <input type="text"/>	

### Teen-LABS (SMAB) Surgeon's Medical Assessment Baseline

**Form completion date:**  /  / 20 (mm/dd/yyyy)    **Completed by (certification no.):**

Please PRINT NEATLY and complete this form in blue or black INK. Mark response boxes like this:

**Has the patient ever had...** (Mark "No" or "Yes" for each item.)

No    Yes

1. Leg swelling accompanied by blistering, infections, discolorations or alterations of the skin

↳ 1.1 *If yes, specify treatment(s) within the past 12 months. (Mark "No" or "Yes" for each item.)*

	<u>No</u>	<u>Yes</u>		<u>No</u>	<u>Yes</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Support hose	<input type="checkbox"/>	<input type="checkbox"/>	Elevation of the legs	
<input type="checkbox"/>	<input type="checkbox"/>	Diuretic	<input type="checkbox"/>	<input type="checkbox"/>	Unna boots	
<input type="checkbox"/>	<input type="checkbox"/>	Operation(s)	<input type="checkbox"/>	<input type="checkbox"/>	Sequential compression boots	
<input type="checkbox"/>	<input type="checkbox"/>	Blood thinners	<input type="checkbox"/>	<input type="checkbox"/>	Other <i>specify:</i> _____	

2. Filter placement to prevent blood clot

3. Angina    *If yes →* 3.1 Symptoms in past 12 months?  No     Yes

↳ *If yes, classification level (see page 3):*  
 I     II     III     IV

4. Hypertension

5. Abnormal EKG but unable to assess ischemia

6. Treatment for irregular heart beat

7. Percutaneous Coronary Intervention

8. CABG

9. Heart valve operation

10. CHF    *If yes →* 10.1 NYHC (see page 3):  I     II     III     IV     Unknown

11. COPD    *If yes →* 11.1 Operation on lungs for COPD?  No     Yes

12. Sleep apnea    *If yes →* 12.1 Operation for sleep apnea?     No     Yes

12.2 Currently use C-PAP/Bi-PAP?  No     Yes

↳ *If yes, frequency of use (see page 3):*  
 Rarely     Often  
 Sometimes     Always

13. Stroke    *If yes →* 13.1 Specify permanent problems resulting from stroke. (Mark "No" or "Yes" for each item.)

	<u>No</u>	<u>Yes</u>		<u>No</u>	<u>Yes</u>
<input type="checkbox"/>	<input type="checkbox"/>	Sensory	<input type="checkbox"/>	<input type="checkbox"/>	Speech problems
<input type="checkbox"/>	<input type="checkbox"/>	Motor	<input type="checkbox"/>	<input type="checkbox"/>	Memory or cognitive

Site ID: Subject ID: **Teen-LABS (SMAB) Surgeon's Medical Assessment Baseline***(Continued) Has the patient ever had... (Mark "No" or "Yes" for each item.)*No Yes

14. Pulmonary hypertension
15. Hypoxemia/hypercarbia syndrome
16. Cor pulmonale
17. Pseudotumor cerebri (PTC) *If yes* →
18. Coagulopathy
19. History of ventral hernia

17.1 Undergone surgery for PTC?  No  Yes↳ 19.1 *If yes, specify signs, symptoms, and treatments for hernia. (Mark "No" or "Yes" for each item.)*No YesNo Yes

- Asymptomatic hernia, no prior operation
- Symptomatic or incarcerated hernia
- Successful repair
- Chronic evisceration through large hernia with associated complication or multiple failed hernia repairs
- ↳ Specify month/year: \_\_\_\_ / \_\_\_\_   Recurrent hernia or size > 15 cm

*Has the patient ever had any of these surgeries... (Mark "No" or "Yes" for each and specify how surgery was performed.)*

<u>No</u>	<u>Yes</u>		<i>If yes</i>	<u>Method of surgical procedure</u> (Mark all that apply.)
<input type="checkbox"/>	<input type="checkbox"/>	20. GERD surgery	→	<input type="checkbox"/> Laparoscopic <input type="checkbox"/> Open
<input type="checkbox"/>	<input type="checkbox"/>	21. Paraesophageal hernia repair	→	<input type="checkbox"/> Laparoscopic <input type="checkbox"/> Open
<input type="checkbox"/>	<input type="checkbox"/>	22. Diaphragmatic defect repair	→	<input type="checkbox"/> Laparoscopic <input type="checkbox"/> Open
<input type="checkbox"/>	<input type="checkbox"/>	23. Splenectomy	→	<input type="checkbox"/> Laparoscopic <input type="checkbox"/> Open
<input type="checkbox"/>	<input type="checkbox"/>	24. Gastroschisis surgery	→	<input type="checkbox"/> Laparoscopic <input type="checkbox"/> Open
<input type="checkbox"/>	<input type="checkbox"/>	25. Gastrostomy	→	<input type="checkbox"/> Laparoscopic <input type="checkbox"/> Open
<input type="checkbox"/>	<input type="checkbox"/>	26. Appendectomy	→	<input type="checkbox"/> Laparoscopic <input type="checkbox"/> Open
<input type="checkbox"/>	<input type="checkbox"/>	27. Cholecystectomy	→	<input type="checkbox"/> Laparoscopic <input type="checkbox"/> Open
<input type="checkbox"/>	<input type="checkbox"/>	28. Small bowel operation	→	<input type="checkbox"/> Laparoscopic <input type="checkbox"/> Open
<input type="checkbox"/>	<input type="checkbox"/>	29. Large bowel operation	→	<input type="checkbox"/> Laparoscopic <input type="checkbox"/> Open
<input type="checkbox"/>	<input type="checkbox"/>	30. Surgery for stress urinary incontinence	→	<input type="checkbox"/> Laparoscopic <input type="checkbox"/> Open
<input type="checkbox"/>	<input type="checkbox"/>	31. Bladder operation	→	<input type="checkbox"/> Laparoscopic <input type="checkbox"/> Open
<input type="checkbox"/>	<input type="checkbox"/>	32. Ovarian procedure	→	<input type="checkbox"/> Laparoscopic <input type="checkbox"/> Open
<input type="checkbox"/>	<input type="checkbox"/>	33. Other GYN procedure	→	<input type="checkbox"/> Laparoscopic <input type="checkbox"/> Open
<input type="checkbox"/>	<input type="checkbox"/>	34. Other abdominal procedure	→	<input type="checkbox"/> Laparoscopic <input type="checkbox"/> Open
<input type="checkbox"/>	<input type="checkbox"/>	35. Other prior laparoscopy		
<input type="checkbox"/>	<input type="checkbox"/>	36. Other prior laparotomy		
<input type="checkbox"/>	<input type="checkbox"/>	37. Surgery for Blount's disease		
<input type="checkbox"/>	<input type="checkbox"/>	38. Surgery for slipped capital femoral epiphysis		
<input type="checkbox"/>	<input type="checkbox"/>	39. Operation for peripheral edema		

Site ID:

Subject ID:

## Teen-LABS (SMAB) Surgeon's Medical Assessment Baseline

### Canadian Cardiovascular Society Classification Level

- Class I:** Ordinary physical activity, such as walking several blocks or climbing stairs does not cause angina. Angina will occur with strenuous, rapid, or prolonged exertion at work or recreation.
- Class II:** Moderate exertion, such as walking or climbing rapidly, walking uphill, walking or stair climbing after meals, in wind, or when under emotional stress or during periods after awakening, or walking more than 2 level blocks, or climbing more than one flight of stairs causes limiting anginal symptoms. Comfort at rest. Slight limitation of ordinary activity.
- Class III:** Ordinary physical activity, such as walking 1-2 level blocks or climbing one flight of stairs at a normal pace, causes limiting anginal symptoms. Comfort at rest. Marked limitation of ordinary activity.
- Class IV:** Any physical activity that causes limiting symptoms. Anginal symptoms may be present at rest with prior exertional angina.

### New York Heart Association Classification

- Class I:** Symptoms with more than ordinary activity; no limitations. Ordinary physical activity does not cause undue fatigue, dyspnea, or palpitations.
- Class II:** Symptoms with ordinary activity; slight limitation of physical activity. Such participants are comfortable at rest. Ordinary physical activity results in fatigue palpitations, dyspnea, or angina.
- Class III:** Symptoms with minimal activity; marked limitation of physical activity. Although participants are comfortable at rest, less-than-ordinary activity leads to fatigue, dyspnea, palpitations, or angina.
- Class IV:** Symptoms at rest; symptomatic at rest. Symptoms of CHF are present at rest; discomfort increases with any physical activity.
- Unknown:** The NYHC has not been noted in the participant's chart and the PI or primary surgeon is not able to determine this classification based on the above definitions.

### Definitions of "frequency of use" if patients use C-PAP/Bi-PAP

- |                   |                         |                |                             |
|-------------------|-------------------------|----------------|-----------------------------|
| <b>Rarely:</b>    | Less than once per week | <b>Often:</b>  | About every day             |
| <b>Sometimes:</b> | About 3 times per week  | <b>Always:</b> | I use it every time I sleep |

<b>Site ID:</b> <input type="text"/>	<b>Subject ID:</b> <input type="text"/>	<b>Reviewed by (certification no.):</b> <input type="text"/>	
<b>Visit:</b> <input type="text"/>	<b>For coordinator use only.</b>	<b>Review date:</b> <input type="text"/> / <input type="text"/> / <input type="text"/>	

### Teen-LABS (SMAF) Surgeon's Medical Assessment Follow-up

**Form completion date:**  /  / 20 (mm/dd/yyyy)    **Completed by (certification no.):**

Please PRINT NEATLY and complete this form in blue or black INK. Mark response boxes like this:

**This form is used to capture conditions *since the patient's last study visit*. By that, we mean the following:**

- At the 6 and 12 month visits, use the time frame "*in the past 6 months.*"
- At the 24 month visit, and subsequent annual follow-ups, use the time frame "*in the past 12 months.*"

**Use these time frames even if the patient missed a scheduled follow-up visit.**

*Since the patient's last study visit, has the patient had... (Mark "No" or "Yes" for each item.)*

No    Yes

1. Leg swelling accompanied by blistering, infections, discolorations or alterations of the skin

↳ 1.1 *If yes, specify treatment(s) since the patient's last study visit. (Mark "No" or "Yes" for each item.)*

<u>No</u>	<u>Yes</u>		<u>No</u>	<u>Yes</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Support hose	<input type="checkbox"/>	<input type="checkbox"/>	Elevation of the legs
<input type="checkbox"/>	<input type="checkbox"/>	Diuretic	<input type="checkbox"/>	<input type="checkbox"/>	Unna boots
<input type="checkbox"/>	<input type="checkbox"/>	Operation(s)	<input type="checkbox"/>	<input type="checkbox"/>	Sequential compression boots
<input type="checkbox"/>	<input type="checkbox"/>	Blood thinners	<input type="checkbox"/>	<input type="checkbox"/>	Other <i>specify:</i> _____

2. Filter placement to prevent blood clot

3. Angina *If yes* → 3.1 Symptoms since last study visit?  No     Yes → *If yes, classification level (see pg 2):*  
 I     II     III     IV

4. Hypertension

5. Abnormal EKG but unable to assess ischemia

6. Treatment for irregular heart beat

7. Percutaneous Coronary Intervention

8. CABG

9. Heart valve operation

10. CHF    *If yes* → 10.1 NYHC (see page 2):  I     II     III     IV     Unknown

11. COPD    *If yes* → 11.1 Operation on lungs for COPD?  No     Yes

12. Sleep apnea *If yes* → 12.1 Operation for sleep apnea?     No     Yes  
 12.2 Currently use C-PAP/Bi-PAP?  No     Yes → *If yes, frequency of use: (see page 2)*  
 Rarely     Often  
 Sometimes     Always

13. Stroke    *If yes* → 13.1 Specify permanent problems resulting from stroke. (*Mark "No" or "Yes" for each item.*)

<u>No</u>	<u>Yes</u>		<u>No</u>	<u>Yes</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Sensory	<input type="checkbox"/>	<input type="checkbox"/>	Speech problems
<input type="checkbox"/>	<input type="checkbox"/>	Motor	<input type="checkbox"/>	<input type="checkbox"/>	Memory or cognitive

Site ID:    Subject ID:         
 Visit:

### Teen-LABS (SMAF) Surgeon's Medical Assessment Follow-up

(Continued) Since the patient's last study visit, has the patient had... (Mark "No" or "Yes" for each item.)

No Yes

- 14. Pulmonary hypertension
- 15. Hypoxemia/hypercarbia syndrome
- 16. Cor pulmonale
- 17. Pseudotumor cerebri (PTC)    *If yes* →
- 18. Coagulopathy
- 19. Ventral hernia

17.1 Undergone surgery for PTC?  No     Yes

↳ 19.1 *If yes, specify signs, symptoms, and treatments for hernia. (Mark "No" or "Yes" for each item.)*

No Yes

- Asymptomatic hernia, no prior operation
- Symptomatic or incarcerated hernia
- Successful repair

No Yes

- Chronic evisceration through large hernia with associated complication or multiple failed hernia repairs
- Recurrent hernia or size > 15 cm

↳ Specify month/year:  /

Canadian Cardiovascular Society Classification Level

- Class I:** Ordinary physical activity, such as walking several blocks or climbing stairs does not cause angina. Angina will occur with strenuous, rapid, or prolonged exertion at work or recreation.
- Class II:** Moderate exertion, such as walking or climbing rapidly, walking uphill, walking or stair climbing after meals, in wind, or when under emotional stress or during periods after awakening, or walking more than 2 level blocks, or climbing more than one flight of stairs causes limiting anginal symptoms. Comfort at rest. Slight limitation of ordinary activity.
- Class III:** Ordinary physical activity, such as walking 1-2 level blocks or climbing one flight of stairs at a normal pace, causes limiting anginal symptoms. Comfort at rest. Marked limitation of ordinary activity.
- Class IV:** Any physical activity that causes limiting symptoms. Anginal symptoms may be present at rest with prior exertional angina.

New York Heart Association Classification

- Class I:** Symptoms with more than ordinary activity; no limitations. Ordinary physical activity does not cause undue fatigue, dyspnea, or palpitations.
- Class II:** Symptoms with ordinary activity; slight limitation of physical activity. Such participants are comfortable at rest. Ordinary physical activity results in fatigue palpitations, dyspnea, or angina.
- Class III:** Symptoms with minimal activity; marked limitation of physical activity. Although participants are comfortable at rest, less-than-ordinary activity leads to fatigue, dyspnea, palpitations, or angina.
- Class IV:** Symptoms at rest; symptomatic at rest. Symptoms of CHF are present at rest; discomfort increases with any physical activity.
- Unknown:** The NYHC has not been noted in the participant's chart and the PI or primary surgeon is not able to determine this classification based on the above definitions.

Definitions of "frequency of use" if patients use C-PAP/Bi-PAP

- Rarely:** Less than once per week                      **Often:** About every day
- Sometimes:** About 3 times per week                      **Always:** I use it every time I sleep

Site ID: Subject ID: Reviewed by (certification no.): 

For coordinator use only.

Review date:  /  / **Teen-LABS (RYB) Roux-en-Y Gastric Bypass**Form completion date:  /  /  (mm/dd/yyyy) Completed by (certification no.): Date of Surgery:  /  /  (mm/dd/yyyy)Please PRINT NEATLY and complete this form in blue or black INK. Mark response boxes like this: 

## 1. POUCH STAPLING MEASUREMENTS:

	How was it measured?				
	String	Ruler	Grasper	Visually	Not done
1.1 Total length of staple line: <input type="text"/> . <input type="text"/> cm →	<input type="checkbox"/>				

2. Type of stapling line:  Partitioned  Divided →2.1 What approach was used at the lesser curve?  
 Pars flaccida dissection  Perigastric dissection

## 3. Record the staple height for the pouch (mark "No" or "Yes" for each):

<u>No</u>	<u>Yes</u>		<u>No</u>	<u>Yes</u>	
<input type="checkbox"/>	<input type="checkbox"/>	2.5 millimeters	<input type="checkbox"/>	<input type="checkbox"/>	4.5 millimeters
<input type="checkbox"/>	<input type="checkbox"/>	3.5 millimeters	<input type="checkbox"/>	<input type="checkbox"/>	Other, specify: <input type="text"/> mm

4. Identify the manufacturer of the stapling device:  U.S. Surgical ® Ethicon ® Other *specify*: \_\_\_\_\_5. Was a banding ring used?  No  Yes →

5.1 Specify the type of reinforcement:

- Silastic ring  
 Patient's fascia  
 Synthetic mesh  
 Other *specify*: \_\_\_\_\_

6. Route of alimentary limb ascension:  Ante-colic, Ante-gastric  Retro-colic, Ante-gastric Ante-colic, Retro-gastric  Retro-colic, Retro-gastric

## 7. LIMB MEASUREMENTS:

	How was it measured?				
	String	Ruler	Grasper	Visually	Not done
7.1 Length of the biliopancreatic limb: <input type="text"/> . <input type="text"/> cm →	<input type="checkbox"/>				
7.2 Length of the alimentary limb: <input type="text"/> . <input type="text"/> cm →	<input type="checkbox"/>				
7.3 Length of the common channel: <input type="text"/> . <input type="text"/> cm →	<input type="checkbox"/>				

8. Configuration used for the proximal (Gastric-Jejunum) anastomosis:  Side-to-side  End-to-side  End-to-end

Site ID: Subject ID: 

For coordinator use only.

**Teen-LABS (RYB) Roux-en-Y Gastric Bypass**9. Method of proximal (Gastric-Jejunum) anastomosis (mark "No" or "Yes" for each):No   Yes
  Hand sewn → 9.1 Stitch type:  Absorbable    Non-absorbable  
 9.2 Stitch layers:  One layer    Two layers

  Linear stapled → 9.3 Height of staples (mark all that apply):  
 0.75 mm    1.0 mm    1.5 mm    2.0 mm  
 2.5 mm    3.5 mm    4.5 mm    Other, specify: \_\_\_\_\_ mm

9.4 Staple manufacturer:

 U.S. Surgical ®    Ethicon ®    Other, specify: \_\_\_\_\_
  Circular stapled → 9.5 Diameter of stapler:  21 mm    25 mm    Other, specify: \_\_\_\_\_ mm

9.6 Staple manufacturer:

 U.S. Surgical ®    Ethicon ®    Other, specify: \_\_\_\_\_

9.7 Pre-closure height of staples (mark all that apply):

 2.5 mm    3.5 mm    4.5 mm    4.8 mm    Other, specify: \_\_\_\_\_ mm

10. Was a method used to test anastomoses?

 No    Yes → If yes, complete table below:

Method (mark "No" or "Yes" for each)	Results	If any of the tests were positive, was an action taken?	Action (mark "No" or "Yes" for each)
1. Air by tube: <input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/> Neg <input type="checkbox"/> Pos		1. Suture repair: <input type="checkbox"/> No <input type="checkbox"/> Yes
2. Air by endoscopy: <input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/> Neg <input type="checkbox"/> Pos	<input type="checkbox"/> No <input type="checkbox"/> Yes →	2. Glue: <input type="checkbox"/> No <input type="checkbox"/> Yes
3. Methylene Blue: <input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/> Neg <input type="checkbox"/> Pos		3. Complete anastomosis redo: <input type="checkbox"/> No <input type="checkbox"/> Yes

11. Specify additional protectant used around the Gastric-Jejunum anastomosis creation (mark "No" or "Yes" for each):No   Yes
  Seal  
  Buttress → was omentum used?  No    Yes  
  Sutures  
  Other, specify: \_\_\_\_\_
12. Was a drain placed at the Gastric-Jejunum anastomosis creation?  No    Yes13. Record the configuration used for the distal (Jejunum-Jejunum) anastomosis:  Side-to-side    End-to-side



### Teen-LABS (GS) Gastric Sleeve

**Form completion date:**   /   /     (mm/dd/yyyy)
 **Completed by (certification no.):**

**Date of Surgery:**   /   /     (mm/dd/yyyy)

Please PRINT NEATLY and complete this form in blue or black INK. Mark response boxes like this:

**1. SLEEVE STAPLING MEASUREMENTS:**

	How was it measured?				
	String	Ruler	Grasper	Visually	Not done
1.1 Total length of staple line: <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> cm →	<input type="checkbox"/>				
1.2 Bougie/tube size: <input type="text"/> <input type="text"/> Fr	(N/A)				
1.3 Distance from the Pylorus to the sleeve staple line: <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> cm →	<input type="checkbox"/>				

2. Type of stapling line:  Partitioned  Divided

**3. Record the staple height for the sleeve (mark "No" or "Yes" for each):**

No   Yes

- a. 1.0 millimeters
- b. 1.5 millimeters
- c. 2.0 millimeters
- d. 2.5 millimeters
- e. 3.5 millimeters
- f. 4.5 millimeters
- g. Other single height cartridge, specify:   .   mm
- h. Other multiple height cartridge, specify:   .   mm     .   mm     .   mm
- i. Other multiple height cartridge, specify:   .   mm     .   mm     .   mm

**4. Identify the manufacturer of the stapling device:**

U.S. Surgical ®    Ethicon ®    Other, specify:

**5. Was a method used to test anastomoses?**

No    Yes → *If yes, complete table below:*

Method (mark "No" or "Yes" for each)	Results	If any of the tests were positive, was an action taken?	Action (mark "No" or "Yes" for each)
1. Air by tube: <input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/> Neg <input type="checkbox"/> Pos		1. Suture repair: <input type="checkbox"/> No <input type="checkbox"/> Yes
2. Air by endoscopy: <input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/> Neg <input type="checkbox"/> Pos	<input type="checkbox"/> No <input type="checkbox"/> Yes →	2. Glue: <input type="checkbox"/> No <input type="checkbox"/> Yes
3. Methylene Blue: <input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/> Neg <input type="checkbox"/> Pos		3. Complete anastomosis redo: <input type="checkbox"/> No <input type="checkbox"/> Yes

Site ID:

Subject ID:

For coordinator use only.

### Teen-LABS (GS) Gastric Sleeve

6. Was reinforcement used?

No  Yes →

6.1 If yes, Specify type (mark "No" or "Yes" to each):

No   Yes

   a. Buttress

   b. Sealant

   c. Suture

   d. Other, specify:

7. Was a banding ring used?

No  Yes →

7.1 Specify the type of reinforcement:

Silastic ring

Patient's fascia

Synthetic mesh

Other, specify:

8. Were the laterjet nerves seen?  No  Yes

9. Were the laterjet nerves cut?  No  Yes →

9.1 Specify:  Partially cut  Completely cut

10. On a scale of 1 to 10, with 1 being "easy" and 10 being "very difficult," circle the level of difficulty in performing the surgical procedure from start to finish:

Easy

1

2

3

4

5

6

7

8

9

10

Very difficult

11. Was there difficulty due to intra-abdominal fat distribution?  No  Yes

12. Was there difficulty due to thick abdominal wall?  No  Yes

13. Was there difficulty due to limited exposure due to enlarged/fatty liver?  No  Yes

14. Was there difficulty due to adhesion from previous surgery?  No  Yes

Site ID:

Subject ID:

Reviewed by (certification no.):

**For coordinator use only.**

Review date:  /  /

### Teen-LABS (AGB) Adjustable Gastric Band

Form completion date:  /  / 20 (mm/dd/yyyy) Completed by (certification no.):

Date of Surgery:  /  / 20 (mm/dd/yyyy)

Please PRINT NEATLY and complete this form in blue or black INK. Mark response boxes like this:

1. Length/circumference of band:  9.75 cm  AP™ Small  
 10 cm  AP™ Large  
 11 cm (or Vanguard ®)  Other, specify:  cm

2. Was a balloon sizer used prior to band placement?  No  Yes

3. Volume of fluid in the band at the end of the operation:  (cc)

4. Method of band fixation:  Sutures → 

4.1 Were they running sutures? <input type="checkbox"/> No <input type="checkbox"/> Yes → # of bites: <input type="text"/>
4.2 Were they interrupted sutures? <input type="checkbox"/> No <input type="checkbox"/> Yes → # of sutures: <input type="text"/>

Other specify: \_\_\_\_\_  
 Not done

5. Port: 5.1 Position:  On top of the anterior rectus sheath  
 Under the anterior sheath  
 Other specify: \_\_\_\_\_

5.2 Number of sutures:

6. Type of brand:  Inamed ®  
 Other specify: \_\_\_\_\_

7. Was the fat pad resected/mobilized?  No  Yes

8. Band placement approach used (mark "No" or "Yes" for each):

<u>No</u>	<u>Yes</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Pars Flaccida
<input type="checkbox"/>	<input type="checkbox"/>	Perigastric
<input type="checkbox"/>	<input type="checkbox"/>	Other specify: _____

9. Does the patient have evidence of a hiatal hernia?  No  Yes

10. Were the laterjet nerves seen?  No  Yes

11. Were the laterjet nerves cut?  No  Yes → 

11.1 Specify: <input type="checkbox"/> Partially cut <input type="checkbox"/> Completely cut
--

Site ID:

Subject ID:

For coordinator use only.

### Teen-LABS (AGB) Adjustable Gastric Band

12. On a scale of 1 to 10, with 1 being "easy" and 10 being "very difficult," circle the level of difficulty in performing the surgical procedure from start to finish:

Easy

1

2

3

4

5

6

7

8

9

10

Very difficult

13. Was there difficulty due to intra-abdominal fat distribution?  No  Yes
14. Was there difficulty due to thick abdominal wall?  No  Yes
15. Was there difficulty due to limited exposure due to enlarged/fatty liver?  No  Yes
16. Was there difficulty due to adhesion from previous surgery?  No  Yes

Site ID: Subject ID: Reviewed by (certification no.): 

For coordinator use only.

Review date:  /  / **Teen-LABS (AGBP) Adjustment to Gastric Band Procedure**Form completion date:  /  /  (mm/dd/yyyy) Completed by (certification no.): Date of Surgery:  /  /  Date of adjustment:  /  / Please PRINT NEATLY and complete this form in blue or black INK. Mark response boxes like this: 

1. Was an adjustment attempted?

 No  Yes →

1.1 Specify reason(s) for adjustment (mark "No" or "Yes" for each):

<u>No</u>	<u>Yes</u>		<u>No</u>	<u>Yes</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Routine	<input type="checkbox"/>	<input type="checkbox"/>	Esophageal Dilatation
<input type="checkbox"/>	<input type="checkbox"/>	Weight gain	<input type="checkbox"/>	<input type="checkbox"/>	Solid food intolerance
<input type="checkbox"/>	<input type="checkbox"/>	Lack of weight loss	<input type="checkbox"/>	<input type="checkbox"/>	Reflux symptoms
<input type="checkbox"/>	<input type="checkbox"/>	Reduced early satiety	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy
<input type="checkbox"/>	<input type="checkbox"/>	Nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Other <i>specify</i> : _____
<input type="checkbox"/>	<input type="checkbox"/>	Increased appetite/hunger			

2. Was an U.G.I. performed?

 No  Yes →If yes, specify based on the **most recent** radiological study:2.1 Date of radiological study:  /  / 2.2 Angle of band relative to the vertical:  ° (degree)

2.3 Specify reason(s) for U.G.I. (mark "No" or "Yes" for each):

<u>No</u>	<u>Yes</u>		<u>No</u>	<u>Yes</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Routine	<input type="checkbox"/>	<input type="checkbox"/>	Esophageal Dilatation
<input type="checkbox"/>	<input type="checkbox"/>	Weight gain	<input type="checkbox"/>	<input type="checkbox"/>	Solid food intolerance
<input type="checkbox"/>	<input type="checkbox"/>	Lack of weight loss	<input type="checkbox"/>	<input type="checkbox"/>	Reflux symptoms
<input type="checkbox"/>	<input type="checkbox"/>	Reduced early satiety	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy
<input type="checkbox"/>	<input type="checkbox"/>	Nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Other <i>specify</i> : _____
<input type="checkbox"/>	<input type="checkbox"/>	Increased appetite/hunger			

3. Was the procedure done at bedside or under fluoroscopy?  Bedside  Under fluoroscopy4. Was access to the port successful?  No → **Stop, do not complete the rest of this form.** Yes

5. Fluid in band:

5.1 Volume recovered: . cc5.2 Volume at the end of the procedure: . cc6. Type of fluid in band:  Saline  Other *specify*: \_\_\_\_\_7. Total time of adjustment:  minutes  seconds

	Site ID: <input type="text"/>	Subject ID: <input type="text"/>	Reviewed by (certification no.): <input type="text"/>	
<b>For coordinator use only.</b>			Review date: <input type="text"/>	<input type="text"/>

### Teen-LABS (PATH1) Liver Pathology Biopsy Demographics

**Form completion date:**  /  / 20 (mm/dd/yyyy)    **Completed by (certification no.):**

Please PRINT NEATLY and complete this form in blue or black INK. Mark response boxes like this:

1. Biopsy date:  /  / 20 (mm/dd/yyyy)

2. Biopsy site (mark "No" or "Yes" for each) and type.

No    Yes

    Right lobe → Specify type:  Needle biopsy     Wedge biopsy     Both

    Left Lobe → Specify type:  Needle biopsy     Wedge biopsy     Both

3. Biopsy size:  # of portal areas

4. Biopsy length:  mm

5. Overall adequacy assessment:  Adequate     Sub-optimal     Inadequate

6. Stains availability: (Mark "No" or "Yes" for each.)

No    Yes

    H&E

    Masson Trichrome

    Iron

    Other specify: \_\_\_\_\_

7. Total number of slides prepared for research:

8. Location of slides:  Pathology department at local Teen-LABS site     Research department at local Teen-LABS site

Site ID: Subject ID: Reviewed by (certification no.): **For coordinator use only.**Review date:  /  / **Teen-LABS (PATH2) Liver Pathology Evaluation****Form completion date:**  /  / 20 (mm/dd/yyyy) **Completed by (certification no.):** Please PRINT NEATLY and complete this form in blue or black INK. Mark response boxes like this: **SECTION 1: NASH CRN FEATURE SCORING SYSTEM**

1. Steatosis grade:
  - 0 (0%)
  - 0 trace (<5%)
  - 1 (5-33%)
  - 2 (33-67%)
  - 3 (>67%)
2. Steatosis location:
  - Predominantly zone 3
  - Predominantly zone 1
  - Azonal
  - Panacinar
3. Microvesicular steatosis:
  - 0 Not present in contiguous patches
  - 1 Present in contiguous patches
4. Fibrosis stage:
  - 0 (None)
  - 1 (Periportal OR Perisinusoidal)
 

↳ 4.1 Specify:  1A (Mild perisinusoidal - Trichrome only)

1B (Moderate perisinusoidal only)

1C (Periportal only)
  - 2 (Periportal AND Perisinusoidal)
  - 3 (Bridging fibrosis)
  - 4 (Cirrhosis)
5. Lobular inflammation:
  - 0 None
  - 1 Mild (<2 foci per 20x high power field)
  - 2 Moderate (2-4 foci per 20x field)
  - 3 Marked (>4 foci per 20x field)
6. Microgranulomas:
  - 0 Absent
  - 1 Present
7. Lipogranulomas:
  - 0 Absent
  - 1 Present
8. Portal inflammation:
  - 0 None
  - 1 No more than mild
  - 2 More than mild
9. Ballooning hepatocellular injury:
  - 0 None
  - 1 Few, less characteristic
  - 2 Many, prominent
10. Acidophil bodies:
  - 0 None
  - 1 More than rare
11. Pigmented macrophages:
  - 0 None to rare
  - 1 More than rare
12. Megamitochondria:
  - 0 None to rare
  - 1 More than rare
13. Mallory bodies:
  - 0 None to rare
  - 1 More than rare
14. Glycogen nuclei:
  - 0 Not present in contiguous patches
  - 1 Present in contiguous patches
15. NASH Activity Score (0-8): 

*(Calculated, sum of steatosis grade [with trace steatosis counted as a 0], lobular inflammation and ballooning injury -- items 1, 5, and 9)*

Site ID:

Subject ID:

For coordinator use only.

**Teen-LABS (PATH2) Liver Pathology Evaluation****SECTION 2: MODIFIED ISHAK HAI**

1. Piecemeal necrosis:
  - 0 Absent
  - 1 Mild
  - 2 Mild/moderate
  - 3 Moderate
  - 4 Severe
2. Confluent necrosis:
  - 0 Absent
  - 1 Focal confluent necrosis
  - 2 Zone 3 necrosis in some areas
  - 3 Zone 3 in most areas
  - 4 Zone 3 necrosis + occasional portal-central bridging
  - 5 Zone 3 necrosis + multiple portal-central bridging
  - 6 Panacinar or multiacinar necrosis
3. Focal (spotty) necrosis:
  - 0 Absent
  - 1 One focus or less per 10x objective
  - 2 Two to four foci per 10x objective
  - 3 Five to ten foci per 10x objective
  - 4 More than ten foci per 10x objective
4. Portal inflammation:
  - 0 None
  - 1 Mild, some or all portal areas
  - 2 Moderate, some or all portal areas
  - 3 Moderate/marked, some or all portal areas
  - 4 Marked, all portal areas
5. Fibrosis:
  - 0 No fibrosis
  - 1 Fibrous expansion of some portal areas
  - 2 Fibrous expansion of most portal areas
  - 3 Occasional portal to portal bridging
  - 4 Marked bridging
  - 5 Marked bridging with occasional nodules
  - 6 Cirrhosis, probable or definite

**SECTION 3: IRON ASSESSMENT (same as planned for NASH CRN, only if iron stain available)**

1. Hepatocellular Iron Grade:
  - 0 Absent or barely discernible, 40x
  - 1 Barely discernible granules, 20x
  - 2 Discrete granules resolved, 10x
  - 3 Discrete granules resolved, 4x
  - 4 Masses visible by naked eye
2. Hepatocellular Iron Distribution:
  - Periportal
  - Periportal and midzonal
  - Panacinar
  - Zone 3 / Nonzonal
3. Sinusoidal Lining Cell Iron:
  - 0 None
  - 1 Mild
  - 2 More than mild
4. Sinusoidal Lining Cell Iron Distribution:
  - Large vessel endothelium only
  - Portal/fibrous bands only (beyond 1st category)
  - Intraparenchymal only
  - Portal and intraparenchymal

Site ID:

Subject ID:

For coordinator use only.

## Teen-LABS (PATH2) Liver Pathology Evaluation

### SECTION 4: DIAGNOSTIC ASSESSMENT

1. Steatohepatitis:
  - Not steatohepatitis
  - Possible/borderline steatohepatitis (Type 1, typical zone 3 pattern)
  - Possible/borderline steatohepatitis (Type 2, zone 1 pattern)
  - Definite steatohepatitis
2. Chronic Hepatitis:
  - Not chronic hepatitis
  - Possible chronic hepatitis
  - Definite chronic hepatitis

### SECTION 5: OTHER NOTES

1. Are there other notes?
  - No
  - Yes
2. If yes, record other notes:

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Site ID:

Subject ID:

Reviewed by (certification no.):

For coordinator use only.

Review date:  /  /

### Teen-LABS (SQOP) Surgeon's Questionnaire/Operative Evaluation

Form completion date:  /  /  (mm/dd/yyyy) Completed by (certification no.):

Please PRINT NEATLY and complete this form in blue or black INK. Mark response boxes like this:

1. Date of surgery:  /  /

2. Operative times: (military time hh:mm)

2.1 Time patient entered the operating room:  :

2.2 Time in which the first open or laparoscopic incision was made:  :

2.3 Time in which the final skin closure was made:  :

2.4 Time in which the patient left the operating room:  :

3. Duration of anesthesia: (military time hh:mm)

3.1 Time of tube insertion:  :

3.2 Time of tube removal (or time when patient left the OR if tube remained in):  :

4. Was surgery cancelled after anesthesia induction?

No  Yes → *If yes, do not complete the remainder of this form.*

5. Is this procedure a revision?

No  Yes

6. Is this procedure a reversal?

No  Yes

7. Operation performed:

Gastric bypass →

Biliopancreatic diversion (BPD) →

Biliopancreatic diversion with Duodenal Switch (BPDS) →

Adjustable band

Sleeve gastrectomy - initial stage

Banded Gastric bypass (Gastric bypass & non-adjustable band)

Vertical Banded Gastroplasty

Other, specify:

7.1 *If Gastric bypass, BPD, or BPDS: Was this a second stage procedure following a sleeve gastrectomy?*  
 No  Yes

8. Anesthesia risk-derived classification

Stage I  Stage II  Stage III  Stage IV

Site ID:

Subject ID:

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### Teen-LABS (SQOP) Surgeon's Questionnaire/Operative Evaluation

9. Were any DVT prophylaxis administered (pre-operative or intra-operative) or ordered (post-operative)?

No  Yes



9.1 Mark "No" or "Yes" to each item

No Yes

		Pre-Operative Administration Timing					Intra-Operative Administration		Post-operatively ordered	
		None	1-2 hrs	Within 1 hr	Within 30 min	>2 hrs	No	Yes	No	Yes
<input type="checkbox"/>	<input type="checkbox"/> a. Compression stockings									
<input type="checkbox"/>	<input type="checkbox"/> b. Sequential compression device									
<input type="checkbox"/>	<input type="checkbox"/> c. Prophylactic vena cava filter									
<input type="checkbox"/>	<input type="checkbox"/> d. Foot pump									
<input type="checkbox"/>	<input type="checkbox"/> e. 5000 units sub-cutaneous heparin	→ <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	→ <input type="checkbox"/>	<input type="checkbox"/>	→ <input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> f. Other dose heparin; Dose: <input type="text"/> units	→ <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	→ <input type="checkbox"/>	<input type="checkbox"/>	→ <input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> g. Low molecular weight heparin	→ <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	→ <input type="checkbox"/>	<input type="checkbox"/>	→ <input type="checkbox"/>	<input type="checkbox"/>

↳ If low molecular weight heparin:  
 20 mg  40 mg  60 mg  Other, specify:  mg

h. Other Anticoagulant →      →   →

↳ Name:   
 Dose:  mg  units

10. Were any pre-operative antibiotics used?

No  Yes



Antibiotic code	Dose (mg)	Time given (military)	Location administered	
10.1 <input type="text"/>	<input type="text"/> mg	<input type="text"/> : <input type="text"/>	<input type="checkbox"/> Pre-surg holding room	<input type="checkbox"/> Operating room
10.2 <input type="text"/>	<input type="text"/> mg	<input type="text"/> : <input type="text"/>	<input type="checkbox"/> Pre-surg holding room	<input type="checkbox"/> Operating room
10.3 <input type="text"/>	<input type="text"/> mg	<input type="text"/> : <input type="text"/>	<input type="checkbox"/> Pre-surg holding room	<input type="checkbox"/> Operating room

Antibiotic codes:

<u>code</u> <u>name</u>	<u>code</u> <u>name</u>
01 Ancef® (cephalosporin - 1st generation)	08 Mefoxin® (Cefoxitin)
02 Cefotan® (cephalosporin - 3rd generation)	09 Zosyn® (Piperacillin/Tazobactam)
03 Vancocin® (Vancomycin)	10 Cleocin® (Clindamycin)
04 Levaquin® (Levofloxacin)	11 Garamycin® (Gentamicin/Gentamycin)
05 Unasyn® (Ampicillin/Sulbactam)	07 Other, specify: <input type="text"/>
06 Flagyl® (Metronidazole)	

11. Placement of central line?

No  Yes

12. Placement of arterial line?

No  Yes

Site ID:

Subject ID:

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### Teen-LABS (SQOP) Surgeon's Questionnaire/Operative Evaluation

13. Record fluids and blood loss during surgery:

a. Crystalloid fluids:  ml

c. Blood loss:  cc (if less than 50cc, enter '0')

b. Colloid fluids:  ml

d. Blood transfusion:  units

14. Overall size of liver:  Normal  Large  Extremely large

15. Liver appearance:  Normal  Abnormal



If abnormal, complete the following:

15.1 Liver color:  Dark red (normal)  Pale pink (fatty)  Congested/Engorged/Nutmeg

15.2 Surface appearance:  Smooth (normal)  Nodular (cirrhotic)

Surface scarring  Other, specify:

15.3 Consistency:  Normal  Firm  Hard

15.4 Mass lesion:  No  Single  Multiple

15.5 Evidence of portal hypertension:  No  Yes



If yes, complete the following:

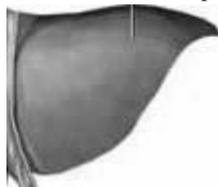
15.5.1 Splenomegaly:  No  Yes  Could not observe

15.5.2 Varices:  No  Yes  Could not observe

15.5.3 Other:  No  Yes, specify:

16. On a scale of 1 to 5, with 1 being gauged as normal and sharp and 5 being gauged as thick and rounded, circle the level of the sharpness of the edge of the left lateral segment of the liver.

The left lateral segment of the liver is normal and sharp



1

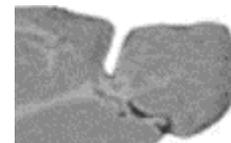
2

3

4

5

The left lateral segment of the liver is thick and rounded



Site ID:

Subject ID:

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### Teen-LABS (SQOP) Surgeon's Questionnaire/Operative Evaluation

17. Method of surgical procedure:

Laparoscopic →

a. # of ports/incisions for each width (enter '0' if none):

5mm    10-12mm    15mm    >=20mm

Laparoscopic converted to open →

a. # of ports/incisions for each width (enter '0' if none):

5mm    10-12mm    15mm    >=20mm

b. Specify reason for conversion (mark "No" or "Yes" for each item):

No    Yes                      No    Yes

Exposure                        Instrument/equipment failure

Bleeding                          Other, specify:

Anatomy

c. Length of open incision:

.  cm

Open (no laparoscopic ports) →

a. Length of open incision:

.  cm

18. Was a resident or trainee present?

No     Yes



18.1 Was the resident or trainee involved in the Gastric-Jejunum anastomosis?     No     Yes     N/A

18.2 Was the resident or trainee involved in the Jejunum-Jejunum anastomosis?     No     Yes     N/A

18.3 Was the resident or trainee involved in the Duodenal-Jejunum anastomosis?     No     Yes     N/A

Site ID:

Subject ID:

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### Teen-LABS (SQOP) Surgeon's Questionnaire/Operative Evaluation

19. Were any concurrent procedures performed?

No → Skip to question 20 on page 6

Yes → Complete the following table. Mark "No" or "Yes" to each item.

No	Yes	Concurrent Procedures																					
<input type="checkbox"/>	<input type="checkbox"/>	a. Liver biopsy																					
↳ a1. Area of biopsy: <input type="checkbox"/> Right lobe <input type="checkbox"/> Left lobe <input type="checkbox"/> Both lobes a2. Indication for biopsy: <table border="0"> <thead> <tr> <th>No</th> <th>Yes</th> <th></th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Research protocol</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Routine/standard of care</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Signs or symptoms of liver disease</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Abnormal pre-op LFTs</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Abnormal appearance of liver in O.R.</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Other, specify: <input type="text"/></td> </tr> </tbody> </table>			No	Yes		<input type="checkbox"/>	<input type="checkbox"/>	Research protocol	<input type="checkbox"/>	<input type="checkbox"/>	Routine/standard of care	<input type="checkbox"/>	<input type="checkbox"/>	Signs or symptoms of liver disease	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal pre-op LFTs	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal appearance of liver in O.R.	<input type="checkbox"/>	<input type="checkbox"/>	Other, specify: <input type="text"/>
No	Yes																						
<input type="checkbox"/>	<input type="checkbox"/>	Research protocol																					
<input type="checkbox"/>	<input type="checkbox"/>	Routine/standard of care																					
<input type="checkbox"/>	<input type="checkbox"/>	Signs or symptoms of liver disease																					
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal pre-op LFTs																					
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal appearance of liver in O.R.																					
<input type="checkbox"/>	<input type="checkbox"/>	Other, specify: <input type="text"/>																					
		a3. Were there any complications? <input type="checkbox"/> No <input type="checkbox"/> Yes → If complication, specify: <input type="text"/>																					

No	Yes	Concurrent Procedures	If yes, were there any complications?		If complication, specify:
			No	Yes	
<input type="checkbox"/>	<input type="checkbox"/>	b. Drain placed at gastrojejunostomy	<input type="checkbox"/>	<input type="checkbox"/>	→
<input type="checkbox"/>	<input type="checkbox"/>	c. Gastrostomy	<input type="checkbox"/>	<input type="checkbox"/>	→
<input type="checkbox"/>	<input type="checkbox"/>	d. Unplanned splenectomy	<input type="checkbox"/>	<input type="checkbox"/>	→
<input type="checkbox"/>	<input type="checkbox"/>	e. Umbilical hernia	<input type="checkbox"/>	<input type="checkbox"/>	→
<input type="checkbox"/>	<input type="checkbox"/>	f. Crural repair	<input type="checkbox"/>	<input type="checkbox"/>	→
<input type="checkbox"/>	<input type="checkbox"/>	g. Partial Gastrectomy	<input type="checkbox"/>	<input type="checkbox"/>	→
<input type="checkbox"/>	<input type="checkbox"/>	h. Subtotal gastrectomy	<input type="checkbox"/>	<input type="checkbox"/>	→
<input type="checkbox"/>	<input type="checkbox"/>	i. Cholecystectomy	<input type="checkbox"/>	<input type="checkbox"/>	→
<input type="checkbox"/>	<input type="checkbox"/>	j. Diagnostic EGD/EGJ <i>Note: This item should NOT be marked if it was only used to check the integrity of the anastomosis.</i>	<input type="checkbox"/>	<input type="checkbox"/>	→
<input type="checkbox"/>	<input type="checkbox"/>	k. Truncal Vagotomy	<input type="checkbox"/>	<input type="checkbox"/>	→
<input type="checkbox"/>	<input type="checkbox"/>	l. Partial Vagotomy	<input type="checkbox"/>	<input type="checkbox"/>	→
<input type="checkbox"/>	<input type="checkbox"/>	m. Panniculectomy	<input type="checkbox"/>	<input type="checkbox"/>	→
<input type="checkbox"/>	<input type="checkbox"/>	n. Planned fiberoptic intubation	<input type="checkbox"/>	<input type="checkbox"/>	→
<input type="checkbox"/>	<input type="checkbox"/>	o. Incisional hernia	<input type="checkbox"/>	<input type="checkbox"/>	→
<input type="checkbox"/>	<input type="checkbox"/>	p. Lysis of extensive adhesions	<input type="checkbox"/>	<input type="checkbox"/>	→
<input type="checkbox"/>	<input type="checkbox"/>	q. Other, specify:	<input type="checkbox"/>	<input type="checkbox"/>	→

Site ID: Subject ID: 

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## Teen-LABS (SQOP) Surgeon's Questionnaire/Operative Evaluation

20. Does the patient have a ventral hernia?

 No  Yes

20.1 Specify the features of the ventral hernia (mark "No" or "Yes" for each item).

No Yes Features

- a. Symptomatic
- b. Prior abdominopelvic surgery
- c. Prior hernia repair in this area
- d. Contents incarcerated

↳ If yes, Evidence of bowel compromise?  No  Yes20.2 Width of fascial defect (largest dimension): .  cm

21. Lowest reported body temperature:

.  °C→ 21.1 Specify temperature source:  Skin (including cartilage)  Core22. Did the patient have any Intra-Operative events? No → Stop completing this form Yes → Complete the following table, continues on following pages. Mark "No" or "Yes" to each item.**No Yes Intra-Operative Events**  22.1 Anesthesia-related complications

↳ 22.1.1 Specify Event(s) by code - see page 8 for Anesthesia codes and complications

Code # 1.  2.  3.  4.  5.   22.2 Hypercapnia (presence of carbon dioxide in the circulating blood more than 50 for a period of at least 10 minutes)  22.3 Hypoxemia (overt signs or symptoms indicative of inadequate oxygen intake or use for a period of at least 10 minutes measured via arterial line measurements)  22.4 Revision of Anastomosis

↳ 22.4.1 Specify (mark "No" or "Yes" to each):

No Yes  GastrojejunostomyNo Yes  JejunostomyNo Yes  Other specify:   22.5 Instrument/equipment failure

↳ 22.5.1 Specify cause (mark "No" or "Yes" to each):

No Yes  Staple misfireNo Yes  Trocar injuryNo Yes  Other specify:

Site ID: Subject ID: 

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## Teen-LABS (SQOP) Surgeon's Questionnaire/Operative Evaluation

No	Yes	<u>Intra-Operative Events</u> , <i>continued</i>
<input type="checkbox"/>	<input type="checkbox"/>	22.6 Diaphragmatic injury ↳ 22.6.1 Specify grade: <input type="checkbox"/> Grade I <input type="checkbox"/> Grade II <input type="checkbox"/> Grade III <input type="checkbox"/> Grade IV <input type="checkbox"/> Grade V 22.6.2 Did this require suture or other repair? <input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/>	<input type="checkbox"/>	22.7 Liver laceration ↳ 22.7.1 Specify grade: <input type="checkbox"/> Grade I <input type="checkbox"/> Grade II <input type="checkbox"/> Grade III <input type="checkbox"/> Grade IV <input type="checkbox"/> Grade V 22.7.2 Did this require suture or other repair? <input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/>	<input type="checkbox"/>	22.8 Splenic injury ↳ 22.8.1 Specify grade: <input type="checkbox"/> Grade I <input type="checkbox"/> Grade II <input type="checkbox"/> Grade III <input type="checkbox"/> Grade IV <input type="checkbox"/> Grade V 22.8.2 Did this lead to organ loss? <input type="checkbox"/> No <input type="checkbox"/> Yes 22.8.3 Did this require suture or other repair? <input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/>	<input type="checkbox"/>	22.9 Mesenteric bleeding/hematoma
<input type="checkbox"/>	<input type="checkbox"/>	22.10 Colon laceration ↳ 22.10.1 Specify grade: <input type="checkbox"/> Grade I <input type="checkbox"/> Grade II <input type="checkbox"/> Grade III <input type="checkbox"/> Grade IV <input type="checkbox"/> Grade V 22.10.2 Did this require suture or other repair? <input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/>	<input type="checkbox"/>	22.11 Urethral injury (including Foley catheter problems) ↳ 22.11.1 Specify grade: <input type="checkbox"/> Grade I <input type="checkbox"/> Grade II <input type="checkbox"/> Grade III <input type="checkbox"/> Grade IV <input type="checkbox"/> Grade V 22.11.2 Did this require suture or other repair? <input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/>	<input type="checkbox"/>	22.12 Pancreatic injury ↳ 22.12.1 Specify grade: <input type="checkbox"/> Grade I <input type="checkbox"/> Grade II <input type="checkbox"/> Grade III <input type="checkbox"/> Grade IV <input type="checkbox"/> Grade V 22.12.2 Did this require suture or other repair? <input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/>	<input type="checkbox"/>	22.13 Large vessel (named vessel) laceration ↳ 22.13.1 Did this require suture or other repair? <input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/>	<input type="checkbox"/>	22.14 Esophageal injury ↳ 22.14.1 Specify grade: <input type="checkbox"/> Grade I <input type="checkbox"/> Grade II <input type="checkbox"/> Grade III <input type="checkbox"/> Grade IV <input type="checkbox"/> Grade V 22.14.2 Did this require suture or other repair? <input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/>	<input type="checkbox"/>	22.15 Bowel injury ↳ 22.15.1 Specify grade: <input type="checkbox"/> Grade I <input type="checkbox"/> Grade II <input type="checkbox"/> Grade III <input type="checkbox"/> Grade IV <input type="checkbox"/> Grade V 22.15.2 Did this require suture or other repair? <input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/>	<input type="checkbox"/>	22.16 Bleeding ( $\geq 2$ units blood loss)



Site ID:

Subject ID:

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### Teen-LABS (SQOP) Surgeon's Questionnaire/Operative Evaluation

23. Event tracking. Review items 22.1 through 22.27. If any are marked "Yes," they must be recorded in the table below. Specify item number (e.g., 22.17) and outcome as of the form completion date. If item number refers to a selection of 'other,' please specify that complication. (See below for outcome status definitions.)

<u>Item</u>	<u>Specify if item was other (for 22.27)</u>	<u>Outcome</u>	
<input type="text"/> . <input type="text"/>	<input type="text"/>	<input type="checkbox"/> Resolved	<input type="checkbox"/> Controlled
		<input type="checkbox"/> Continuing	<input type="checkbox"/> Death
<input type="text"/> . <input type="text"/>	<input type="text"/>	<input type="checkbox"/> Resolved	<input type="checkbox"/> Controlled
		<input type="checkbox"/> Continuing	<input type="checkbox"/> Death
<input type="text"/> . <input type="text"/>	<input type="text"/>	<input type="checkbox"/> Resolved	<input type="checkbox"/> Controlled
		<input type="checkbox"/> Continuing	<input type="checkbox"/> Death
<input type="text"/> . <input type="text"/>	<input type="text"/>	<input type="checkbox"/> Resolved	<input type="checkbox"/> Controlled
		<input type="checkbox"/> Continuing	<input type="checkbox"/> Death
<input type="text"/> . <input type="text"/>	<input type="text"/>	<input type="checkbox"/> Resolved	<input type="checkbox"/> Controlled
		<input type="checkbox"/> Continuing	<input type="checkbox"/> Death
<input type="text"/> . <input type="text"/>	<input type="text"/>	<input type="checkbox"/> Resolved	<input type="checkbox"/> Controlled
		<input type="checkbox"/> Continuing	<input type="checkbox"/> Death
<input type="text"/> . <input type="text"/>	<input type="text"/>	<input type="checkbox"/> Resolved	<input type="checkbox"/> Controlled
		<input type="checkbox"/> Continuing	<input type="checkbox"/> Death
<input type="text"/> . <input type="text"/>	<input type="text"/>	<input type="checkbox"/> Resolved	<input type="checkbox"/> Controlled
		<input type="checkbox"/> Continuing	<input type="checkbox"/> Death
<input type="text"/> . <input type="text"/>	<input type="text"/>	<input type="checkbox"/> Resolved	<input type="checkbox"/> Controlled
		<input type="checkbox"/> Continuing	<input type="checkbox"/> Death
<input type="text"/> . <input type="text"/>	<input type="text"/>	<input type="checkbox"/> Resolved	<input type="checkbox"/> Controlled
		<input type="checkbox"/> Continuing	<input type="checkbox"/> Death
<input type="text"/> . <input type="text"/>	<input type="text"/>	<input type="checkbox"/> Resolved	<input type="checkbox"/> Controlled
		<input type="checkbox"/> Continuing	<input type="checkbox"/> Death
<input type="text"/> . <input type="text"/>	<input type="text"/>	<input type="checkbox"/> Resolved	<input type="checkbox"/> Controlled
		<input type="checkbox"/> Continuing	<input type="checkbox"/> Death

#### Outcome Status Definitions for question 23

- Resolved:** Patient returned to previous health status with no subsequent problems.
- Continuing:** Patient has not yet returned to previous health status and is still being actively managed for the complication.
- Controlled:** Complication is present, but is controlled (chronic management).
- Death:** Death has occurred due to complication.

Site ID:




Subject ID:







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## Teen-LABS (SQOP) Surgeon's Questionnaire/Operative Evaluation

### APPENDIX A Bariatric Anesthesia Events

<u>Code</u>	<u>Event</u>	<u>Code</u>	<u>Event</u>
01	Dental fracture or avulsion	25	Failure to extract intact esophageal probes
02	Nose bleeds, severe	26	Allergic reaction, severe
03	Soft tissue injury: upper airway	27	Ocular injury, minor
04	Unplanned fiber optic intubation	28	Ocular injury, major
05	Difficult, successful intubation (>2 attempts by laryngoscopist not in training)	29	Severe endocrine disturbance
06	Cannot intubate, successful mask ventilation	30	Malignant hyperthermia
07	Unsuccessful airway management, wake-up without sequelae	31	Positional injury
08	Use of airway rescue device (LMA, LMA-fastrach, Tracheal Esophageal Combitublightwand, etc.) after failed airway management	32	Integument injury
09	Cannot intubate, cannot ventilate	33	Acute renal insufficiency, failure
10	Invasive airway, by anesthesia	34	Congestive heart failure
11	Surgical airway required	35	Myocardial (cardiac) ischemia
12	Esophageal intubation, unwitnessed	36	Myocardial infarction
13	Laryngospasm	37	Sustained dysrhythmia
14	Bronchospasm	38	Sustained hypoxia
15	Negative-pressure pulmonary edema	39	Sustained hypotension
16	Witnessed aspiration	40	Sustained hypercarbia
17	Pneumothorax	41	Peripheral nerve injury
18	Rupture of bleb (<2 cm), bulla (>2 cm)	42	Stroke
19	Postoperative pneumonia	43	Hypoxic encephalopathy
20	Pulmonary edema	44	Coma or impaired consciousness
21	Re-intubation, within 24 hours	45	Cardiac arrest
22	Re-intubation, within 48 hours	46	Death
23	Prolonged postoperative intubation (>4 hours)	47	Case cancellation, involving anesthesia
24	Perforation of gastrointestinal tract by esophageal probes	48	Miscellaneous

### APPENDIX B Injury Scales

<b>6. Diaphragm injury scale</b>		
<u>Grade</u>	<u>Injury Description</u>	<u>AIS-90</u>
I	Contusion	2
II	Laceration <=2cm	3
III	Laceration 2-10 cm	3
IV	Laceration >10 cm with tissue loss <=25cm <sup>2</sup>	3
V	Laceration with tissue loss >25 cm <sup>2</sup>	3

<b>7. Liver injury scale - laceration</b>		
<u>Grade</u>	<u>Injury Description</u>	<u>AIS-90</u>
I	Capsular tear, <1cm parenchymal depth	2
II	Capsular tear, 1-3 cm parenchymal depth, <10 cm in length	2
III	>3 cm parenchymal depth	3
IV	Parenchymal disruption involving 25% - 75% of hepatic lob or 1-3 Couinaud's segments within a single lobe	4
V	Parenchymal disruption involving >75% of hepatic lob or >3 Couinaud's segments within a single lobe	5

Site ID:

Subject ID:

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**Teen-LABS (SQOP) Surgeon's Questionnaire/Operative Evaluation****APPENDIX B, continued****Injury Scales**

<b>8. Spleen scale - laceration</b>		
<b>Grade</b>	<b>Injury Description</b>	<b>AIS-90</b>
I	Capsular tear, <1 cm parenchymal depth	2
II	Capsular tear, 1-3 cm parenchymal depth, which does not involve a trabecular vessel	2
III	>3 cm parenchymal depth or involving trabecular vessels	3
IV	Laceration involving segmental or hilar vessels producing major devascularization (>25% of spleen)	4
V	Complete shattered spleen	5

<b>10. Colon injury - laceration</b>		
<b>Grade</b>	<b>Injury Description</b>	<b>AIS-90</b>
I	Partial thickness, no perforation	2
II	Laceration <50% of circumference	3
III	Laceration >=50% of circumference without transection	3
IV	Transection of the colon	4
V	Transection of the colon with segmental tissue loss	4

<b>11. Urethra injury - laceration</b>			
<b>Grade</b>	<b>Injury Type</b>	<b>Injury Description</b>	<b>AIS-90</b>
I	Contusion	Blood at urethral meatus: urethrography normal	2
II	Stretch injury	Elongation of urethra without extravasation on urethrography	3
III	Partial disruption	Extravasation of urethrography contrast at injury site with contrast visualized in the bladder	3
IV	Complete disruption	Extravasations of urethrography contrast at injury site without visualization in the bladder; <=2 cm of urethral separation	4
V	Complete disruption	Complete transection with >2 cm urethral separation, or extension into the prostate or vagina	4

<b>12. Pancreas injury - laceration</b>		
<b>Grade</b>	<b>Injury Description</b>	<b>AIS-90</b>
I	Superficial laceration without duct injury	2
II	Major laceration without duct injury or tissue loss	3
III	Distal transection or parenchymal injury with duct injury	3
IV	Proximal transection or parenchymal injury involving ampulla	4
V	Massive disruption of pancreatic head	5

<b>14. Esophagus injury</b>		
<b>Grade</b>	<b>Injury Description</b>	<b>AIS-90</b>
I	Contusion/Hematoma	2
	Partial-thickness laceration	3
II	Laceration <=50% circumference	3
III	Laceration >50% circumference	4
IV	Segmental loss or devascularization <=2 cm	4
V	Segmental loss or devascularization >2 cm	5

<b>15. Bowel injury</b>		
<b>Grade</b>	<b>Injury Description</b>	<b>AIS-90</b>
I	Contusion or hematoma without devascularization	2
II	Laceration <50% circumference	3
III	Laceration >= 50% circumference without transection	3
IV	Transection of the small bowel with segmental tissue loss	4
V	Devascularized segment	4

Site ID: Subject ID: Reviewed by (certification no.): 

For coordinator use only.

Review date:  /  / 

## Teen-LABS (DS) Discharge Summary

Form completion date:  /  /  (mm/dd/yyyy)Completed by (certification no.): Date of Surgery:  /  /  (mm/dd/yyyy)Please PRINT NEATLY and complete this form in blue or black INK. Mark response boxes like this: 

1. Were any post-operative anticoagulation therapy received prior to discharge?

 No  Yes

Mark "No" or "Yes" for each item. If yes, specify use, number of days, and times per day.

No	Yes	If yes	Prophylactic (preventative) Use?		# of days	times per day	Therapeutic (as treatment) Use?		# of days	times per day
			No	Yes			No	Yes		
<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
			If yes, specify dose:							
			<input type="checkbox"/> 20 mg		<input type="checkbox"/> 40 mg					
			<input type="checkbox"/> 60 mg		<input type="checkbox"/> Other, specify: <input type="text"/> mg					
<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
			If yes, specify: Name: <input type="text"/>							
			Dose: <input type="text"/> mg <input type="checkbox"/> units							

2. Post-operative pain management. Mark "No" or "Yes" for each item.

No	Yes	No	Yes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/> Other, specify: <input type="text"/>	

3. Patient disposition after surgery:

<input type="checkbox"/> ICU →	If ICU, 3.1 Specify number of days of intubation after surgery: <input type="text"/> (day of surgery is defined as day zero) 3.2 Was the patient reintubated? <input type="checkbox"/> No <input type="checkbox"/> Yes → If yes, number of times: <input type="text"/>
<input type="checkbox"/> Floor with telemetry	
<input type="checkbox"/> Floor without telemetry	
<input type="checkbox"/> Same day discharge	

4. Nutritional therapy at discharge:

- All nutrition per oral  
 Any non-PO enteral feeds  
 Any TPN



Site ID: Subject ID: 

For coordinator use only.

## Teen-LABS (DS) Discharge Summary

## 8. Post-Operative Complications (continued)

No	Yes	Within 30 days	Post-operative complications																								
<input type="checkbox"/>	<input type="checkbox"/> ↳	<input type="checkbox"/>	8.5 Post operative bleeding 8.5.1 Specify location ( <i>mark "No" or "Yes" for each</i> ). <table border="0"> <tr> <td><u>No</u></td> <td><u>Yes</u></td> <td></td> <td><u>No</u></td> <td><u>Yes</u></td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Upper intestine</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Unknown</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Lower intestine</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Other, specify: <input type="text"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Intra-peritoneal</td> <td></td> <td></td> <td></td> </tr> </table> 8.5.2 Specify number of units of blood required: <input type="text"/> <input type="text"/> units	<u>No</u>	<u>Yes</u>		<u>No</u>	<u>Yes</u>		<input type="checkbox"/>	<input type="checkbox"/>	Upper intestine	<input type="checkbox"/>	<input type="checkbox"/>	Unknown	<input type="checkbox"/>	<input type="checkbox"/>	Lower intestine	<input type="checkbox"/>	<input type="checkbox"/>	Other, specify: <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intra-peritoneal			
<u>No</u>	<u>Yes</u>		<u>No</u>	<u>Yes</u>																							
<input type="checkbox"/>	<input type="checkbox"/>	Upper intestine	<input type="checkbox"/>	<input type="checkbox"/>	Unknown																						
<input type="checkbox"/>	<input type="checkbox"/>	Lower intestine	<input type="checkbox"/>	<input type="checkbox"/>	Other, specify: <input type="text"/>																						
<input type="checkbox"/>	<input type="checkbox"/>	Intra-peritoneal																									
<input type="checkbox"/>	<input type="checkbox"/> ↳	<input type="checkbox"/>	8.6 Abdominal abscess 8.6.1 Specify location ( <i>mark "No" or "Yes" for each</i> ). <table border="0"> <tr> <td><u>No</u></td> <td><u>Yes</u></td> <td></td> <td><u>No</u></td> <td><u>Yes</u></td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Left upper quadrant</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Lower abdomen</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Subhepatic</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Other, specify: <input type="text"/></td> </tr> </table>	<u>No</u>	<u>Yes</u>		<u>No</u>	<u>Yes</u>		<input type="checkbox"/>	<input type="checkbox"/>	Left upper quadrant	<input type="checkbox"/>	<input type="checkbox"/>	Lower abdomen	<input type="checkbox"/>	<input type="checkbox"/>	Subhepatic	<input type="checkbox"/>	<input type="checkbox"/>	Other, specify: <input type="text"/>						
<u>No</u>	<u>Yes</u>		<u>No</u>	<u>Yes</u>																							
<input type="checkbox"/>	<input type="checkbox"/>	Left upper quadrant	<input type="checkbox"/>	<input type="checkbox"/>	Lower abdomen																						
<input type="checkbox"/>	<input type="checkbox"/>	Subhepatic	<input type="checkbox"/>	<input type="checkbox"/>	Other, specify: <input type="text"/>																						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8.7 Esophageal injury																								
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8.8 Wound infection (Cellulitis around incision site accompanied by fever)																								
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8.9 Fascial dehiscence																								
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8.10 Seroma of wound																								
<input type="checkbox"/>	<input type="checkbox"/> ↳	<input type="checkbox"/>	8.11 Small bowel obstruction 8.11.1 Specify obstruction: <input type="checkbox"/> Partial obstruction <input type="checkbox"/> Complete obstruction 8.11.2 Specify cause: <input type="checkbox"/> Internal hernia <input type="checkbox"/> Obstructed JJ Anastomosis <input type="checkbox"/> Adhesions <input type="checkbox"/> Unknown <input type="checkbox"/> Anastomotic anatomy <input type="checkbox"/> Other, specify: <input type="text"/>																								
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8.12 Stomal/gastric outlet obstruction																								
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8.13 Stomal stenosis																								
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8.14 GI ulcer(s)																								
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8.15 Ateletasis (significant) (Diagnosis by chest X-ray accompanied by fever)																								
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8.16 Pneumothorax																								
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8.17 Pleural effusion																								
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8.18 Pulmonary embolism																								

Site ID: Subject ID: 

For coordinator use only.

## Teen-LABS (DS) Discharge Summary

## 8. Post-Operative Complications (continued)

No	Yes	Within 30 days	Post-operative complications												
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8.19 Deep vein thrombosis												
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8.20 Pneumonia												
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8.21 Respiratory failure requiring intubation												
	↳		8.21.1 Specify cause: <input type="checkbox"/> ARDS <input type="checkbox"/> PE <input type="checkbox"/> Other, specify: <input type="checkbox"/> Pneumonia <input type="checkbox"/> Unknown <input type="text"/>												
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8.22 Renal/urinary tract infection												
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8.23 Renal failure												
	↳		8.23.1 Specify type of diagnosis ( <i>mark "No" or "Yes" for each</i> ). <table style="width: 100%; border: none;"> <tr> <td style="text-align: center;"><u>No</u></td> <td style="text-align: center;"><u>Yes</u></td> <td style="text-align: center;"><u>No</u></td> <td style="text-align: center;"><u>Yes</u></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td colspan="2" style="text-align: center;">Oliguric/anuric</td> <td colspan="2" style="text-align: center;">Creatinine</td> </tr> </table>	<u>No</u>	<u>Yes</u>	<u>No</u>	<u>Yes</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Oliguric/anuric		Creatinine	
<u>No</u>	<u>Yes</u>	<u>No</u>	<u>Yes</u>												
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>												
Oliguric/anuric		Creatinine													
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8.24 TIA												
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8.25 Stroke												
	↳		8.25.1 Specify type of diagnosis: <input type="checkbox"/> Ischemic <input type="checkbox"/> Hemorrhagic												
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8.26 Urinary retention												
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8.27 New decubitus ulcers (bed sores)												
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8.28 Rhabdomyolysis (defined as CPK's of 5000 or more)												
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8.29 Jaundice												
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8.30 Hepatitis												
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8.31 Liver failure												
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8.32 Acute cholecystitis/biliaric colic												
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8.33 Common bile duct stones/cholangitis												
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8.34 Arrhythmia												
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8.35 Persistent Tachycardia												
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8.36 Myocardial infarction												
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8.37 Cardiac arrest												
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8.38 Death ( <i>Please obtain adjudication information</i> )												
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8.39 Other event that resulted in an unexpected course of action, specify: <input type="text"/>												

Site ID: Subject ID: 

For coordinator use only.

## Teen-LABS (DS) Discharge Summary

9. Complication tracking. Review items 8.1.1 through 8.39. If any are marked "Yes," they must be recorded in the tables below. Specify item number (e.g., 8.5), date of occurrence, and outcome as of the form completion date. If a complication occurred more than once, record EACH INSTANCE on a separate line. If item number refers to a selection of 'other,' please specify that complication. (See below for outcome status definitions.)

Use this table for item 8.1.1 only. Specify item number out to the furthest point (e.g., 8.1.1c).

Item	Specify if item was other	Date (mm/dd/yy)	Outcome
<input type="text"/> . <input type="text"/> . <input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="checkbox"/> Resolved <input type="checkbox"/> Controlled <input type="checkbox"/> Continuing <input type="checkbox"/> Death
<input type="text"/> . <input type="text"/> . <input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="checkbox"/> Resolved <input type="checkbox"/> Controlled <input type="checkbox"/> Continuing <input type="checkbox"/> Death
<input type="text"/> . <input type="text"/> . <input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="checkbox"/> Resolved <input type="checkbox"/> Controlled <input type="checkbox"/> Continuing <input type="checkbox"/> Death
<input type="text"/> . <input type="text"/> . <input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="checkbox"/> Resolved <input type="checkbox"/> Controlled <input type="checkbox"/> Continuing <input type="checkbox"/> Death
<input type="text"/> . <input type="text"/> . <input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="checkbox"/> Resolved <input type="checkbox"/> Controlled <input type="checkbox"/> Continuing <input type="checkbox"/> Death

Use this table for items 8.2 through 8.39

Item	Specify if item was other	Date (mm/dd/yy)	Outcome
<input type="text"/> . <input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="checkbox"/> Resolved <input type="checkbox"/> Controlled <input type="checkbox"/> Continuing <input type="checkbox"/> Death
<input type="text"/> . <input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="checkbox"/> Resolved <input type="checkbox"/> Controlled <input type="checkbox"/> Continuing <input type="checkbox"/> Death
<input type="text"/> . <input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="checkbox"/> Resolved <input type="checkbox"/> Controlled <input type="checkbox"/> Continuing <input type="checkbox"/> Death
<input type="text"/> . <input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="checkbox"/> Resolved <input type="checkbox"/> Controlled <input type="checkbox"/> Continuing <input type="checkbox"/> Death
<input type="text"/> . <input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="checkbox"/> Resolved <input type="checkbox"/> Controlled <input type="checkbox"/> Continuing <input type="checkbox"/> Death
<input type="text"/> . <input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="checkbox"/> Resolved <input type="checkbox"/> Controlled <input type="checkbox"/> Continuing <input type="checkbox"/> Death
<input type="text"/> . <input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="checkbox"/> Resolved <input type="checkbox"/> Controlled <input type="checkbox"/> Continuing <input type="checkbox"/> Death
<input type="text"/> . <input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="checkbox"/> Resolved <input type="checkbox"/> Controlled <input type="checkbox"/> Continuing <input type="checkbox"/> Death
<input type="text"/> . <input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="checkbox"/> Resolved <input type="checkbox"/> Controlled <input type="checkbox"/> Continuing <input type="checkbox"/> Death
<input type="text"/> . <input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="checkbox"/> Resolved <input type="checkbox"/> Controlled <input type="checkbox"/> Continuing <input type="checkbox"/> Death

## Outcome Status Definitions for question 9

**Resolved:** Patient returned to previous health status with no subsequent problems.

**Continuing:** Patient has not yet returned to previous health status and is still being actively managed for the complication.

**Controlled:** Complication is present, but is controlled (chronic management).

**Death:** Death has occurred due to complication.

Site ID: Subject ID: Reviewed by (certification no.): **For coordinator use only.**Review date:  /  / **Teen-LABS (POST) Post-Operative Evaluation Form****Form completion date:**  /  / 20 (mm/dd/yyyy)**Completed by (certification no.):** **Date of surgery:**  /  / 20 (mm/dd/yyyy)Please PRINT NEATLY and complete this form in blue or black INK. Mark response boxes like this: 

1. Source(s) of information: (Mark "No" or "Yes" to each.)

	No	Yes		If yes, specify date of most recent contact (mm/dd/yy)
a. Patient in person	<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="text"/> / <input type="text"/> / <input type="text"/>
b. Patient by telephone	<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="text"/> / <input type="text"/> / <input type="text"/>
c. Patient representative	<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="text"/> / <input type="text"/> / <input type="text"/>
d. Other physician	<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="text"/> / <input type="text"/> / <input type="text"/>
e. Chart review	<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="text"/> / <input type="text"/> / <input type="text"/>

2. Length of hospital stay for obesity surgery:

 days

3. Discharge location:

- Home →
- Rehabilitation facility →
- Skilled nursing facility →
- Other hospital →
- Was not discharged

3.1 Discharge date:

 /  / 

4. Did the patient die?

- No → 4.1 Status date:  /  /  (Most recent date participant known to be alive.)
- Yes → 4.2 Date of death:  /  /  (*Please obtain adjudication information.*)

5. Was the patient re-hospitalized after initial discharge?

- 
- No
- 
- Yes →

5.1 Number of times re-hospitalized: 5.2 Date of first re-hospitalization:  /  / 5.3 Were any of these related to a cardiac event:  No  Yes5.4 Were any of these related to hydration or nutrition:  No  Yes

For EACH hospitalization:

1. Complete an HC
2. Obtain adjudication information

6. Current nutritional therapy:

- All nutrition per oral
- Any non-PO enteral feeds
- Any TPN



Site ID: Subject ID: 

For coordinator use only.

## Teen-LABS (POST) Post-Operative Evaluation Form

## 7. Post discharge complications, continued.

No	Yes	Post-discharge complications																																											
<input type="checkbox"/>	<input type="checkbox"/>	7.16 Port or tube problems																																											
<input type="checkbox"/>	<input type="checkbox"/>	7.17 Gastric prolapse																																											
<input type="checkbox"/>	<input type="checkbox"/>	7.18 Esophageal motility disorder or dilation																																											
<input type="checkbox"/>	<input type="checkbox"/>	7.19 Gastroesophageal reflux																																											
		↳ 7.19.1 How was it identified: <input type="checkbox"/> Symptoms <input type="checkbox"/> pH probe → # measured: <input type="text"/>																																											
<input type="checkbox"/>	<input type="checkbox"/>	7.20 Primary dumping syndrome (including nausea, bloating, diarrhea, colic, within 1 hour of a meal)																																											
<input type="checkbox"/>	<input type="checkbox"/>	7.21 Late-dumping symptoms (including light-headedness, palpitations, sweating, diarrhea, >=1 hour of a meal)																																											
<input type="checkbox"/>	<input type="checkbox"/>	7.22 Nausea or vomiting																																											
		↳ 7.22.1 Specify severity and frequency levels <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th rowspan="2"></th> <th colspan="5">Severity level*</th> <th colspan="5">Frequency level**</th> </tr> <tr> <th>None</th> <th>Mild</th> <th>Moderate</th> <th>Severe</th> <th>Extremely severe</th> <th>None</th> <th>Rare</th> <th>Occasional</th> <th>Frequent</th> <th>Extremely frequent</th> </tr> </thead> <tbody> <tr> <td>Nausea</td> <td><input type="checkbox"/></td> </tr> <tr> <td>Vomiting</td> <td><input type="checkbox"/></td> </tr> </tbody> </table> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div style="width: 48%;"> <p><u>*Severity definitions</u>  <u>None</u>: does not have this complication.  <u>Mild</u>: not influencing usual activities.  <u>Moderate</u>: diverting from, but not urging modification.  <u>Severe</u>: influencing usual activities, severely enough urge modifications.  <u>Extremely severe</u>: requiring hospitalization or bed rest.</p> </div> <div style="width: 48%;"> <p><u>*Frequency definitions</u>  <u>None</u>: does not have this complication.  <u>Rare</u>: 1 time per week.  <u>Occasional</u>: 2 to 3 times per week.  <u>Frequent</u>: 4 to 6 times per week.  <u>Extremely frequent</u>: 7 or more times per week.</p> </div> </div>		Severity level*					Frequency level**					None	Mild	Moderate	Severe	Extremely severe	None	Rare	Occasional	Frequent	Extremely frequent	Nausea	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>																		
	Severity level*					Frequency level**																																							
	None	Mild	Moderate	Severe	Extremely severe	None	Rare	Occasional	Frequent	Extremely frequent																																			
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																			
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																			
<input type="checkbox"/>	<input type="checkbox"/>	7.23 Flatulence (defined as excessive interference with lifestyle)																																											
<input type="checkbox"/>	<input type="checkbox"/>	7.24 Persistent diarrhea (defined as excessive interference with lifestyle)																																											
<input type="checkbox"/>	<input type="checkbox"/>	7.25 Constipation (defined as excessive interference with lifestyle)																																											
<input type="checkbox"/>	<input type="checkbox"/>	7.26 Dehydration (defined as requiring hospitalization)																																											
<input type="checkbox"/>	<input type="checkbox"/>	7.27 Acute renal failure																																											
<input type="checkbox"/>	<input type="checkbox"/>	7.28 Liver failure																																											
<input type="checkbox"/>	<input type="checkbox"/>	7.29 Myocardial infarction																																											
<input type="checkbox"/>	<input type="checkbox"/>	7.30 Cardiac arrest																																											
<input type="checkbox"/>	<input type="checkbox"/>	7.31 Hypoglycemia (defined by abnormally low blood glucose measured within 3 hours after a meal)																																											
<input type="checkbox"/>	<input type="checkbox"/>	7.32 Symptomatic hypoglycemia (defined by abnormally low blood glucose measured within 3 hours after a meal; plus altered mental status, or loss of consciousness, or seizure, or blurred vision, or weakness, or dizziness)																																											
<input type="checkbox"/>	<input type="checkbox"/>	7.33 Other event that resulted in an unexpected course of action, specify:																																											
		<input style="width: 100%; height: 20px;" type="text"/>																																											

Site ID: Subject ID: 

For coordinator use only.

## Teen-LABS (POST) Post-Operative Evaluation Form

8. Complication tracking. Review items 7.1 through 7.33. If any are marked "Yes," they must be recorded in the table below. Specify item number (e.g., 7.3), date of occurrence, and outcome as of the form completion date. If a complication occurred more than once, record EACH INSTANCE on a separate line. (See below for outcome status definitions.)

Item	Specify if item was other	Date (mm/dd/yy)	Outcome
<input type="checkbox"/> . <input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="checkbox"/> Resolved <input type="checkbox"/> Controlled <input type="checkbox"/> Continuing <input type="checkbox"/> Death
<input type="checkbox"/> . <input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="checkbox"/> Resolved <input type="checkbox"/> Controlled <input type="checkbox"/> Continuing <input type="checkbox"/> Death
<input type="checkbox"/> . <input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="checkbox"/> Resolved <input type="checkbox"/> Controlled <input type="checkbox"/> Continuing <input type="checkbox"/> Death
<input type="checkbox"/> . <input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="checkbox"/> Resolved <input type="checkbox"/> Controlled <input type="checkbox"/> Continuing <input type="checkbox"/> Death
<input type="checkbox"/> . <input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="checkbox"/> Resolved <input type="checkbox"/> Controlled <input type="checkbox"/> Continuing <input type="checkbox"/> Death
<input type="checkbox"/> . <input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="checkbox"/> Resolved <input type="checkbox"/> Controlled <input type="checkbox"/> Continuing <input type="checkbox"/> Death
<input type="checkbox"/> . <input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="checkbox"/> Resolved <input type="checkbox"/> Controlled <input type="checkbox"/> Continuing <input type="checkbox"/> Death
<input type="checkbox"/> . <input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="checkbox"/> Resolved <input type="checkbox"/> Controlled <input type="checkbox"/> Continuing <input type="checkbox"/> Death
<input type="checkbox"/> . <input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="checkbox"/> Resolved <input type="checkbox"/> Controlled <input type="checkbox"/> Continuing <input type="checkbox"/> Death
<input type="checkbox"/> . <input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="checkbox"/> Resolved <input type="checkbox"/> Controlled <input type="checkbox"/> Continuing <input type="checkbox"/> Death
<input type="checkbox"/> . <input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="checkbox"/> Resolved <input type="checkbox"/> Controlled <input type="checkbox"/> Continuing <input type="checkbox"/> Death
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<input type="checkbox"/> . <input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="checkbox"/> Resolved <input type="checkbox"/> Controlled <input type="checkbox"/> Continuing <input type="checkbox"/> Death

## Outcome Status Definitions for question 8

**Resolved:** Patient returned to previous health status with no subsequent problems.  
**Continuing:** Patient has not yet returned to previous health status and is still being actively managed for the complication.  
**Controlled:** Complication is present, but is controlled (chronic management).  
**Death:** Death has occurred due to complication.

Table of codes for suspected reason for an intervention  
(use with question 9 on page 5)

Code	Suspected reason	Code	Suspected reason	Code	Suspected reason
1	Anastomotic leak	6	Pneumonia	11	Gastric distension
2	Other abdominal sepsis	7	Other respiratory failure	12	Strictures
3	Intestinal obstruction	8	Wound infection/evisceration	13	Bleeding
4	DVT	9	Fluid or electrolyte depletion	14	Infection/fever
5	Pulmonary embolism	10	Vomiting or poor intake	15	Other



Site ID:

Subject ID:

For coordinator use only.

### Teen-LABS (POST) Post-Operative Evaluation Form

10. Procedure tracking. Review items 9.1.2 through 9.11. If any are marked "Yes," they must be recorded in the table below. Specify item number and date of occurrence. If a procedure was done more than once, record EACH INSTANCE on a separate line. NOTE: for 9.1.2 specify item number out to the furthest point (e.g., 9.1.2b or 9.1.2cJJ).

*Use this table for item 9.1.2 only\**

<u>Item</u>	<u>Specify if item was other</u>	<u>Date</u> (mm/dd/yy)
<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"/>	<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"/> / <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"/>

*\*Please obtain adjudication information*

*Use this table for items 9.2 through 9.11\**

<u>Item</u>	<u>Specify if item was other</u>	<u>Date</u> (mm/dd/yy)
<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"/>
<input type="text"/> . <input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
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<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"/>

Site ID:

Subject ID:

For coordinator use only.

**Teen-LABS (POST) Post-Operative Evaluation Form**

11. Were any planned post-discharge anticoagulation therapies received?

No  Yes



Mark "No" or "Yes" for each item. If yes, mark "No" or "Yes" for each type of use, and specify number of days, and times per day if used.

No	Yes	If yes	Prophylactic (preventative)		# of days	times per day	Therapeutic (as treatment)		# of days	times per day	
			Use? No	Use? Yes			Use? No	Use? Yes			
<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	
		<i>If yes, specify dose:</i>									
		<input type="checkbox"/> 20 mg <input type="checkbox"/> 40 mg									
		<input type="checkbox"/> 60 mg <input type="checkbox"/> Other, specify: <input type="text"/> . <input type="text"/> mg									
<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	
		<i>If yes, specify:</i>									
		Name: <input type="text"/>									
		Dose: <input type="text"/> . <input type="text"/> <input type="checkbox"/> mg <input type="checkbox"/> units									

Site ID: \_\_\_\_\_ Subject ID: \_\_\_\_\_  
Visit: \_\_\_\_\_

Reviewed by (certification no.): \_\_\_\_\_  
Review date: \_\_\_\_\_

**For coordinator use only – DO NOT SEND THIS PAGE TO THE DCC**

## Teen-LABS (SHORT) Short Form

**Form completion date:** \_\_\_\_\_ (mm/dd/yyyy)

**Please PRINT NEATLY.**

### What are the three best numbers to contact the patient?

Cell Number: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_\_ Can we text you:  No  Yes

Cell Number: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_\_ Can we text you:  No  Yes

Cell Number: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_\_ Can we text you:  No  Yes

### Current address

Street address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Current email: \_\_\_\_\_

### Close relative/friend

Name/relation: \_\_\_\_\_

Phone number: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

Street address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

### Current primary medical doctor

Name/Practice name: \_\_\_\_\_

City/State: \_\_\_\_\_

Phone number or additional info (e.g. website, email): \_\_\_\_\_

### Have you had any other major life events that you want to share? (e.g., marriage, divorce, deaths)

\_\_\_\_\_  
\_\_\_\_\_

### Please answer the following

1. Do you have a Facebook account:

No  Yes -- What is your Facebook account name: \_\_\_\_\_

2. Do you have a MySpace account:

No  Yes -- What is your MySpace account name: \_\_\_\_\_

3. Do you have a Twitter account:

No  Yes -- What is your Twitter account name: \_\_\_\_\_

Site ID:    Subject ID:      
 Reviewed by (certification no.):

Visit:  
 For coordinator use only. Review date:   /   /

**Teen-LABS (SHORT) Short Form**

Date form administered:   /   / 20   (mm/dd/yyyy)
 Administered by (certification no.):

Please PRINT NEATLY and complete this form in blue or black INK. Mark response boxes like this:

**Source of information (mark the one primary respondent):**

Participant
  Caregiver
  Other, specify:

1. Weight.

1.1 Record weight; use appropriate field depending on units reported. Each field should contain a response or code.

.   lbs

.   kg

CODES: '-1' = missing data  
 '-2' = weight given in other units  
 '-3' = participant states weight is unknown  
 '-4' = participant refused to report  
 '-5' = participant has not weighed self

1.2 Date weight was taken. If weight was not reported in 1.1, leave date field blank.

/   /     (mm/dd/yyyy)

1.3 How was weight measured?

- Scale
- Estimate
- Weight was not measured/unknown or participant refused to report

Mark "No" or "Yes" and the relevant sub questions to each of the following.

No Yes

2. Do you currently have high blood pressure?

↳ 2.1 If yes, what, if any, medication do you take for high blood pressure?

- Dietary/lifestyle treatment only
- Single medication
- Multiple medications

3. Do you currently have diabetes?

↳ 3.1 If yes, what, if any, medications are you taking for your diabetes? (Mark "No" or "Yes" for each item.)

No Yes

- a. Oral diabetes medication
- b. Insulin
- c. Non-insulin injectable (e.g., Byetta or Symlin)
- d. No medication (controlled by diet)

4. Do you currently have sleep apnea?

↳ 4.1 If yes, what treatment are you using? (Mark "No" or "Yes" for each item.)

No Yes

- a. CPAP
- b. BiPAP
- c. Other, specify:

Site ID:

Subject ID:

Visit:

For coordinator use only.

### Teen-LABS (SHORT) Short Form

*The next set of questions asks about events since the participant's last visit. Note: if a participant missed their last study visit, this will cover a longer time frame going back to the last visit they did have.*

*Mark "No" or "Yes" and complete the relevant sub questions to each of the following.*

No Yes

5. Since your last visit, have you been hospitalized?

↳ 5.1 *If yes*, number of days hospitalized since your last visit:

(cumulative days of all hospitalizations)

5.2 *If yes*, reason(s) for hospitalization(s):

---

---

No Yes

6. Since your last visit, have you had any in-patient procedures or operations?

↳ 6.1 *If yes*, explain:

---

---

No Yes

7. Since your last visit, have you had any out-patient procedures or operations?  
(e.g., minor surgery, dental procedures, endoscopies, etc., that did not require an overnight stay.)

↳ 7.1 *If yes*, explain:

---

---

*Only ask the following question if the patient is female and over the age of 18. Mark N/A if patient does not meet these criteria.*

N/A No Yes

8. Since your last visit, have you been pregnant?

↳ 8.1 *If yes*, how many times have you been pregnant since your last visit?

times

	Site ID: <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	Subject ID: <input style="width: 20px; height: 20px;" type="text"/>	Reviewed by (certification no.): <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	
Visit: <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	<b>For coordinator use only.</b>		Review date: <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/>	

### Teen-LABS (FO6) 6 Month Follow-Up Form

**Form completion date:**  /  / 20 (mm/dd/yyyy)    **Completed by (certification no.):**

Please PRINT NEATLY and complete this form in blue or black INK. Mark response boxes like this:

*Before completing questions 1, 2, and 3, determine employment and education status prior to weight control surgery. Enter "-2" for questions that are not relevant to the patient.*

1. How many **work days** did you miss because of your weight control surgery? *Note: If the patient is employed part-time, every 2 work days missed should be recorded as 1 day.*

days    Enter "-2" if not employed prior to the operation.

2. How many **days of school** did you miss because of your weight control surgery?

days    Enter "-2" if not a student prior to the operation OR had surgery when school was not in session (e.g., during summer break).

*Ask the next question only if the patient does NOT work outside of the home:*

3. How many **days were you unable** to perform your normal household tasks at home, such as cleaning, cooking, childcare, and/or caring for yourself or family because of your weight control surgery?

days    Enter "-2" if employed outside the home.

**READ:**

I am going to ask you a few questions about weight control strategies you might have used since your weight control surgery.

4. Since your weight control surgery, how many **times** have you seen a counselor/mental health professional **for weight control**?

Never     1 to 5 times     6 to 10 times     11 to 20 times     More than 20 times

5. Since your weight control surgery, how many **times** have you seen a nutritionist/dietitian **for weight control**?

Never     1 to 5 times     6 to 10 times     11 to 20 times     More than 20 times

6. Since your weight control surgery, how many **times** have you seen a personal trainer or exercise specialist **for weight control**?

Never     1 to 5 times     6 to 10 times     11 to 20 times     More than 20 times

7. Since your weight control surgery, how many **weeks** did you participate in group exercise **for weight control**?

.  weeks

8. Since your weight control surgery, how many **weeks** did you participate in a support/self help group **for weight control**?

.  weeks

9. Since your weight control surgery, how many **weeks** did you access a discussion group, bulletin board, or chat room on the internet **for weight control**?

.  weeks

	Site ID: <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	Subject ID: <input style="width: 20px; height: 20px;" type="text"/>	Reviewed by (certification no.): <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	
	Visit: <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	<b>For coordinator use only.</b>	Review date: <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/>	

### Teen-LABS (FOA) Annual Follow-Up Form

**Form completion date:**  /  / 20 (mm/dd/yyyy)    **Completed by (certification no.):**

Please PRINT NEATLY and complete this form in blue or black INK. Mark response boxes like this:

**READ:**

The questions I'm about to ask you are about events that happened since your last study visit. By that, I mean you should:  
*(for 12 month visits)* answer the questions about "the past 6 months."  
*(for 24 month visits)* answer the questions about "the past 12 months."  
 Please use this time frame even if you missed your last follow-up visit.

1. Since your last study visit, how many **work days** did you miss because of your weight control surgery? *Note: If the patient is employed part-time, every 2 work days missed should be recorded as 1 day.*

days    Enter "-2" if not employed prior to the operation.

2. Since your last study visit, how many **days of school** did you miss because of your weight control surgery?

days    Enter "-2" if not a student prior to the operation OR had surgery when school was not in session (e.g., during summer break).

*Ask the next question only if the patient does NOT work outside of the home:*

3. Since your last study visit, how many **days were you unable** to perform your normal household tasks at home, such as cleaning, cooking, childcare, and/or caring for yourself or family because of your weight control surgery?

days    Enter "-2" if employed outside the home.

**READ:**

I am going to ask you a few questions about weight control strategies you might have used since your last study visit.

4. Since your last study visit, how many **times** have you seen a counselor/mental health professional **for weight control**?

Never     1 to 5 times     6 to 10 times     11 to 20 times     More than 20 times

5. Since your last study visit, how many **times** have you seen a nutritionist/dietitian **for weight control**?

Never     1 to 5 times     6 to 10 times     11 to 20 times     More than 20 times

6. Since your last study visit, how many **times** have you seen a personal trainer or exercise specialist **for weight control**?

Never     1 to 5 times     6 to 10 times     11 to 20 times     More than 20 times

7. Since your last study visit, how many **weeks** did you participate in group exercise **for weight control**?

.  weeks

8. Since your last study visit, how many **weeks** did you participate in a support/self help group **for weight control**?

.  weeks

9. Since your last study visit, how many **weeks** did you access a discussion group, bulletin board, or chat room on the internet **for weight control**?

.  weeks



	Site ID: <input type="text"/>	Subject ID: <input type="text"/>			
	Visit: <input type="text"/>	HC ID: <input type="text"/>	<b>For coordinator use only.</b>		

### Teen-LABS (HC) Health Care Utilization form

4. Reason for treatment/care, continued: (Mark "Yes" or "No" to each.)

No   Yes

     **4.2 Renal System Diagnoses**

↳ Mark "Yes" or "No" to each.

<u>No</u>	<u>Yes</u>		<u>No</u>	<u>Yes</u>	
<input type="checkbox"/>	<input type="checkbox"/>	a. Acute renal failure	<input type="checkbox"/>	<input type="checkbox"/>	e. Other renal system related diagnosis
<input type="checkbox"/>	<input type="checkbox"/>	b. Kidney failure or start of dialysis			<i>specify:</i>
<input type="checkbox"/>	<input type="checkbox"/>	c. Severe hypoglycemia			<input style="width: 100%;" type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	d. Pancreatitis			

     **4.3 Vascular System Diagnoses**

↳ Mark "Yes" or "No" to each.

<u>No</u>	<u>Yes</u>		<u>No</u>	<u>Yes</u>	
<input type="checkbox"/>	<input type="checkbox"/>	a. Chest pain or angina	<input type="checkbox"/>	<input type="checkbox"/>	e. PE/DVT
<input type="checkbox"/>	<input type="checkbox"/>	b. Myocardial infarction	<input type="checkbox"/>	<input type="checkbox"/>	f. Other vascular system related diagnosis
<input type="checkbox"/>	<input type="checkbox"/>	c. Congestive heart disease			<i>specify:</i>
<input type="checkbox"/>	<input type="checkbox"/>	d. TIA/Stroke			<input style="width: 100%;" type="text"/>

     **4.4 Respiratory System Diagnoses**

↳ Mark "Yes" or "No" to each.

<u>No</u>	<u>Yes</u>		<u>No</u>	<u>Yes</u>	
<input type="checkbox"/>	<input type="checkbox"/>	a. Acute respiratory failure	<input type="checkbox"/>	<input type="checkbox"/>	e. Pneumonia
<input type="checkbox"/>	<input type="checkbox"/>	b. Pulmonary Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	f. Other respiratory system related diagnosis
<input type="checkbox"/>	<input type="checkbox"/>	c. COPD			<i>specify:</i>
<input type="checkbox"/>	<input type="checkbox"/>	d. Obstructive lung disease			<input style="width: 100%;" type="text"/>

     **4.5 Obesity-Related Diagnoses**

↳ Mark "Yes" or "No" to each.

<u>No</u>	<u>Yes</u>		<u>No</u>	<u>Yes</u>	
<input type="checkbox"/>	<input type="checkbox"/>	a. Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	c. Other obesity related diagnosis
<input type="checkbox"/>	<input type="checkbox"/>	b. Cellulitis			<i>specify:</i>
					<input style="width: 100%;" type="text"/>

     **4.6 Other Diagnoses**

↳ Mark "Yes" or "No" to each.

<u>No</u>	<u>Yes</u>		<u>No</u>	<u>Yes</u>	
<input type="checkbox"/>	<input type="checkbox"/>	a. Gallbladder disease	<input type="checkbox"/>	<input type="checkbox"/>	d. Other diagnosis not listed above
<input type="checkbox"/>	<input type="checkbox"/>	b. Local adiposity			<i>specify:</i>
<input type="checkbox"/>	<input type="checkbox"/>	c. Activity-related injury			<input style="width: 100%;" type="text"/>

Site ID: <input style="width: 40px;" type="text"/>	Subject ID: <input style="width: 80px;" type="text"/>	
Visit: <input style="width: 40px;" type="text"/>	HC ID: <input style="width: 40px;" type="text"/>	<b>For coordinator use only.</b>

### Teen-LABS (HC) Health Care Utilization form

5. Was reason(s) for treatment/care confirmed by medical discharge summary/medical records?

- No     Yes     Medical records ordered, confirmation pending

6. Diagnosis tracking. Review items 4.1 through 4.6. If any are marked "Yes," they must be recorded in the table below. Specify item number out to the letter (e.g., 4.2b), date of occurrence, and outcome as of the form completion date. If a complication occurred more than once, record EACH INSTANCE on a separate line. (See below for outcome status definitions.)

<u>Item</u>	<u>Specify if item was other</u>	<u>Date (mm/dd/yy)</u>	<u>Outcome</u>
<input type="checkbox"/> . <input style="width: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/>	<input type="checkbox"/> Resolved <input type="checkbox"/> Controlled <input type="checkbox"/> Continuing <input type="checkbox"/> Death
<input type="checkbox"/> . <input style="width: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/>	<input type="checkbox"/> Resolved <input type="checkbox"/> Controlled <input type="checkbox"/> Continuing <input type="checkbox"/> Death
<input type="checkbox"/> . <input style="width: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/>	<input type="checkbox"/> Resolved <input type="checkbox"/> Controlled <input type="checkbox"/> Continuing <input type="checkbox"/> Death
<input type="checkbox"/> . <input style="width: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/>	<input type="checkbox"/> Resolved <input type="checkbox"/> Controlled <input type="checkbox"/> Continuing <input type="checkbox"/> Death
<input type="checkbox"/> . <input style="width: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/>	<input type="checkbox"/> Resolved <input type="checkbox"/> Controlled <input type="checkbox"/> Continuing <input type="checkbox"/> Death
<input type="checkbox"/> . <input style="width: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/>	<input type="checkbox"/> Resolved <input type="checkbox"/> Controlled <input type="checkbox"/> Continuing <input type="checkbox"/> Death
<input type="checkbox"/> . <input style="width: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/>	<input type="checkbox"/> Resolved <input type="checkbox"/> Controlled <input type="checkbox"/> Continuing <input type="checkbox"/> Death
<input type="checkbox"/> . <input style="width: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/>	<input type="checkbox"/> Resolved <input type="checkbox"/> Controlled <input type="checkbox"/> Continuing <input type="checkbox"/> Death
<input type="checkbox"/> . <input style="width: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/>	<input type="checkbox"/> Resolved <input type="checkbox"/> Controlled <input type="checkbox"/> Continuing <input type="checkbox"/> Death
<input type="checkbox"/> . <input style="width: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/>	<input type="checkbox"/> Resolved <input type="checkbox"/> Controlled <input type="checkbox"/> Continuing <input type="checkbox"/> Death
<input type="checkbox"/> . <input style="width: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/>	<input type="checkbox"/> Resolved <input type="checkbox"/> Controlled <input type="checkbox"/> Continuing <input type="checkbox"/> Death
<input type="checkbox"/> . <input style="width: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/>	<input type="checkbox"/> Resolved <input type="checkbox"/> Controlled <input type="checkbox"/> Continuing <input type="checkbox"/> Death
<input type="checkbox"/> . <input style="width: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/>	<input type="checkbox"/> Resolved <input type="checkbox"/> Controlled <input type="checkbox"/> Continuing <input type="checkbox"/> Death

**Outcome Status Definitions for question 6**

**Resolved:** Patient returned to previous health status with no subsequent problems.

**Continuing:** Patient has not yet returned to previous health status and is still being actively managed for the complication.

**Controlled:** Complication is present, but is controlled (chronic management).

**Death:** Death has occurred due to complication.

Site ID: <input style="width: 40px;" type="text"/>	Subject ID: <input style="width: 80px;" type="text"/>	
Visit: <input style="width: 40px;" type="text"/>	HC ID: <input style="width: 40px;" type="text"/>	<b>For coordinator use only.</b>

### Teen-LABS (HC) Health Care Utilization form

7. Please specify operation(s)/procedure(s) performed during this hospitalization/out-patient procedure date.  
 (Mark "Yes" or "No" to each.)

No   Yes

**7.1 GI tract or Bariatric Surgery Related Procedures**

↳ Mark "Yes" or "No" to each.

<u>No</u>	<u>Yes</u>		<u>No</u>	<u>Yes</u>	
<input type="checkbox"/>	<input type="checkbox"/>	a. Upper GI tract endoscopy	<input type="checkbox"/>	<input type="checkbox"/>	n. Placement of percutaneous drain
<input type="checkbox"/>	<input type="checkbox"/>	b. Stricture dilation	<input type="checkbox"/>	<input type="checkbox"/>	o. Re-exploration
<input type="checkbox"/>	<input type="checkbox"/>	c. Ventral hernia repair	<input type="checkbox"/>	<input type="checkbox"/>	p. Other revision of bariatric surgery <i>specify:</i>
<input type="checkbox"/>	<input type="checkbox"/>	d. Exploratory laparotomy			<input style="width: 100%;" type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	e. Wound incision, evisceration or revision			
<input type="checkbox"/>	<input type="checkbox"/>	f. Wound drainage	<input type="checkbox"/>	<input type="checkbox"/>	q. Reversal of bariatric surgery <i>specify:</i>
<input type="checkbox"/>	<input type="checkbox"/>	g. Lysis of adhesions			<input style="width: 100%;" type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	h. Gastric revision	<input type="checkbox"/>	<input type="checkbox"/>	r. Removal of excess skin
<input type="checkbox"/>	<input type="checkbox"/>	i. Gastrostomy	<input type="checkbox"/>	<input type="checkbox"/>	s. Other GI tract or bariatric surgery related procedure, <i>specify:</i>
<input type="checkbox"/>	<input type="checkbox"/>	j. Anastomotic revision			<input style="width: 100%;" type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	k. Band/port revision			
<input type="checkbox"/>	<input type="checkbox"/>	l. Band replacement			
<input type="checkbox"/>	<input type="checkbox"/>	m. Operative drain placement			<input style="width: 100%;" type="text"/>

**7.2 Renal System Procedures**

↳ Mark "Yes" or "No" to each.

<u>No</u>	<u>Yes</u>	
<input type="checkbox"/>	<input type="checkbox"/>	a. Dialysis
<input type="checkbox"/>	<input type="checkbox"/>	b. Other renal system related procedure <i>specify:</i>
		<input style="width: 100%;" type="text"/>

**7.3 Vascular System Procedures**

↳ Mark "Yes" or "No" to each.

<u>No</u>	<u>Yes</u>		<u>No</u>	<u>Yes</u>	
<input type="checkbox"/>	<input type="checkbox"/>	a. Cardiac catheterization	<input type="checkbox"/>	<input type="checkbox"/>	e. Other vascular system related procedure, <i>specify:</i>
<input type="checkbox"/>	<input type="checkbox"/>	b. Percutaneous coronary intervention/angioplasty			<input style="width: 100%;" type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	c. Coronary artery bypass graft surgery			
<input type="checkbox"/>	<input type="checkbox"/>	d. Peripheral vascular catheter-based intervention			

**7.4 Respiratory System Procedures**

↳ Mark "Yes" or "No" to each.

<u>No</u>	<u>Yes</u>		<u>No</u>	<u>Yes</u>	
<input type="checkbox"/>	<input type="checkbox"/>	a. Mechanical ventilation	<input type="checkbox"/>	<input type="checkbox"/>	c. Other respiratory system related procedure, <i>specify:</i>
<input type="checkbox"/>	<input type="checkbox"/>	b. Supplemental oxygen			<input style="width: 100%;" type="text"/>

Site ID: <input style="width: 40px;" type="text"/>	Subject ID: <input style="width: 60px;" type="text"/>	
Visit: <input style="width: 40px;" type="text"/>	HC ID: <input style="width: 40px;" type="text"/>	<b>For coordinator use only.</b>

### Teen-LABS (HC) Health Care Utilization form

7. Please specify operation(s)/procedure(s) performed during this hospitalization/out-patient procedure date, continued.  
(Mark "Yes" or "No" to each.)

No   Yes

     **7.5 Elective Procedures**

↳ Mark "Yes" or "No" to each.

<u>No</u>	<u>Yes</u>		<u>No</u>	<u>Yes</u>	
<input type="checkbox"/>	<input type="checkbox"/>	a. Cholecystectomy	<input type="checkbox"/>	<input type="checkbox"/>	e. Liposuction or liposculpture
<input type="checkbox"/>	<input type="checkbox"/>	b. Orthopedic procedure	<input type="checkbox"/>	<input type="checkbox"/>	f. Other elective procedure, specify:
<input type="checkbox"/>	<input type="checkbox"/>	c. Hysterectomy procedure			
<input type="checkbox"/>	<input type="checkbox"/>	d. Plastic procedures other than removal of excess skin			

     **7.6 Other Procedures**

↳ Mark "Yes" or "No" to each.

<u>No</u>	<u>Yes</u>	
<input type="checkbox"/>	<input type="checkbox"/>	a. Non-elective procedure not specified <i>specify:</i> <span style="border: 1px solid black; display: inline-block; width: 150px; height: 20px; vertical-align: middle;"></span>

8. Was the operation(s)/procedure(s) performed during this hospitalization/out-patient procedure confirmed by medical discharge summary/medical records?

No    Yes    Medical records ordered, confirmation pending

9. Was hospitalization/out-patient procedure for an operation?

No    Yes   →

9.1 Was the procedure an abdominal re-operation?

No    Yes   →

9.1.1 Specify approach:

Laparoscopic    Laparoscopic converted to open    Open

10. Procedure tracking. Review items 7.1 through 7.6. If any are marked "Yes," they must be recorded in the table below. Specify item number out to the letter (e.g., 7.2b) and date of occurrence. If a procedure occurred more than once, record EACH INSTANCE on a separate line.

<u>Item</u>	<u>Specify if item was other</u>	<u>Date (mm/dd/yy)</u>
<input type="checkbox"/> . <input style="width: 30px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/>
<input type="checkbox"/> . <input style="width: 30px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/>
<input type="checkbox"/> . <input style="width: 30px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/>
<input type="checkbox"/> . <input style="width: 30px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/>
<input type="checkbox"/> . <input style="width: 30px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/>
<input type="checkbox"/> . <input style="width: 30px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/>
<input type="checkbox"/> . <input style="width: 30px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/>
<input type="checkbox"/> . <input style="width: 30px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/>

Site ID: Subject ID: Reviewed by (certification no.): 

For coordinator use only.

Review date:  /  / **Teen-LABS (INF) Inactivation Form**Form completion date:  /  /  (mm/dd/yyyy) Completed by (certification no.): Please PRINT NEATLY and complete this form in blue or black INK. Mark response boxes like this: 1. Date of Inactivation:  /  /  (mm/dd/yyyy)

(If deceased, date of inactivation is date of death.)

2. Reason for Inactivation:

 Patient refuses further participation Patient excluded from study

↳ If excluded, specify reason:

 Surgery performed by non Teen-LABS certified surgeon Patient did not proceed to surgery

↳ If patient did not proceed to surgery, mark "No" or "Yes" for each:

No   Yes  Lack of insurance coverage  Surgeon's choice

↳ If yes to surgeon's choice, mark "No" or "Yes" for each:

No   Yes  Medical reason  Psycho-social reason  Other specify: \_\_\_\_\_  Patient's choice  Other specify: \_\_\_\_\_ Other specify: \_\_\_\_\_ Patient died Patient too sick to comply with follow-up Patient relocated Patient is untraceable Other specify: \_\_\_\_\_ Unable to schedule baseline visit <14 days notice of surgery3. If not known to be deceased, status date:  /  /  (mm/dd/yyyy)

(Most recent date participant known to be alive.)

<b>Site ID:</b> <input type="text"/>	<b>Subject ID:</b> <input type="text"/>	<b>Reviewed by (certification no.):</b> <input type="text"/>	
<b>Visit:</b> <input type="text"/>	<b>For coordinator use only.</b>	<b>Review date:</b> <input type="text"/> / <input type="text"/> / <input type="text"/>	

### Teen-LABS (CDFU) Complication and Diagnosis Follow-up

**Form completion date:**  /  / 20 (mm/dd/yyyy)    **Completed by (certification no.):**

Please PRINT NEATLY and complete this form in blue or black INK. Mark response boxes like this:

For each complication and/or diagnosis specified, please mark the patient's CURRENT OUTCOME STATUS as of this form's completion date. See outcome status definitions below.

<b>Form:</b> <input type="text"/>	<b>Form completion date:</b> <input type="text"/> / <input type="text"/> / <input type="text"/>	<b>Visit reported:</b> <input type="text"/>	<b>Comp/dx code:</b> <input type="text"/>	<b>Date of complication/dx:</b> <input type="text"/> / <input type="text"/> / <input type="text"/>	<b>STATUS:</b> <input type="checkbox"/> Resolved <input type="checkbox"/> Continuing <input type="checkbox"/> Controlled <input type="checkbox"/> Death <input type="checkbox"/> Unknown
<b>Complication/ diagnosis description:</b>	<input style="width: 100%; height: 40px;" type="text"/>			<b>DCC Comp ID:</b> <input type="text"/>	
<b>Form:</b> <input type="text"/>	<b>Form completion date:</b> <input type="text"/> / <input type="text"/> / <input type="text"/>	<b>Visit reported:</b> <input type="text"/>	<b>Comp/dx code:</b> <input type="text"/>	<b>Date of complication/dx:</b> <input type="text"/> / <input type="text"/> / <input type="text"/>	<b>STATUS:</b> <input type="checkbox"/> Resolved <input type="checkbox"/> Continuing <input type="checkbox"/> Controlled <input type="checkbox"/> Death <input type="checkbox"/> Unknown
<b>Complication/ diagnosis description:</b>	<input style="width: 100%; height: 40px;" type="text"/>			<b>DCC Comp ID:</b> <input type="text"/>	
<b>Form:</b> <input type="text"/>	<b>Form completion date:</b> <input type="text"/> / <input type="text"/> / <input type="text"/>	<b>Visit reported:</b> <input type="text"/>	<b>Comp/dx code:</b> <input type="text"/>	<b>Date of complication/dx:</b> <input type="text"/> / <input type="text"/> / <input type="text"/>	<b>STATUS:</b> <input type="checkbox"/> Resolved <input type="checkbox"/> Continuing <input type="checkbox"/> Controlled <input type="checkbox"/> Death <input type="checkbox"/> Unknown
<b>Complication/ diagnosis description:</b>	<input style="width: 100%; height: 40px;" type="text"/>			<b>DCC Comp ID:</b> <input type="text"/>	
<b>Form:</b> <input type="text"/>	<b>Form completion date:</b> <input type="text"/> / <input type="text"/> / <input type="text"/>	<b>Visit reported:</b> <input type="text"/>	<b>Comp/dx code:</b> <input type="text"/>	<b>Date of complication/dx:</b> <input type="text"/> / <input type="text"/> / <input type="text"/>	<b>STATUS:</b> <input type="checkbox"/> Resolved <input type="checkbox"/> Continuing <input type="checkbox"/> Controlled <input type="checkbox"/> Death <input type="checkbox"/> Unknown
<b>Complication/ diagnosis description:</b>	<input style="width: 100%; height: 40px;" type="text"/>			<b>DCC Comp ID:</b> <input type="text"/>	

**Outcome Status Definitions**

**Resolved:** Patient returned to previous health status with no subsequent problems.

**Continuing:** Patient has not yet returned to previous health status and is still being actively managed for the complication.

**Controlled:** Complication is present, but is controlled (chronic management).

**Death:** Death has occurred due to complication.

	Site ID: <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	Subject ID: <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	Reviewed by (certification no.): <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	
	Visit: <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	<b>For coordinator use only.</b>	Review date: <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> / <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> / <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	

### Teen-LABS (UPR) Unanticipated Problem Report

**Form completion date:**  /  / 20 (mm/dd/yyyy)    **Completed by (certification no.):**

Please PRINT NEATLY and complete this form in blue or black INK. Mark response boxes like this:

Mark the appropriate box for each question as it relates to the reported event. This form assists the investigator and the DCC in determining if problems observed during the Teen-LABS research study represent unanticipated problems posing risk or harm to the research participant(s) or others. All other problems (e.g., problems that are expected AND possibly, probably, or definitely related to the research) are reported on the AE form at the time of occurrence. Unanticipated adverse events are those not described in the informed consent document. **Please provide as much information as possible so that the DCC may conduct a thorough review of the report. Maintain a copy of this form in your study records.**

**1. Mark type of event:**

- Adverse event(s) that is/are BOTH: Unexpected AND related or possibly related to participation in the research
- An event that requires a change to the protocol and/or informed consent
- Information that indicates a change to the risks or potential benefits of the research (i.e., An interim analysis indicates that participants have a lower rate of response to treatment than initially expected; safety monitoring indicates that a particular side effect is more severe, or more frequent than initially expected; a paper is published from another study that shows that an arm of the study is of no therapeutic value)
- Breach of confidentiality
- Change in labeling or withdrawal from marketing for safety reasons of a drug, device, or biologic used in a research protocol
- Change to the protocol made without prior IRB review to eliminate an apparent immediate hazard to a research participant
- Protocol violation (meaning an accidental or unintentional change to the IRB approved protocol that harmed a participant or others or indicates that participant or others are at increased risk of harm)
- Incarceration of a participant in a protocol not approved to enroll prisoners
- Complaint of a participant that indicates unexpected risks or cannot be resolved by the research team
- Other unanticipated problem posing risk to subjects or others comparable to the events listed above. Note that prompt reporting is required only for events that are both UNEXPECTED/UNANTICIPATED and have a reasonable possibility of relatedness to the research.
- INVESTIGATIONAL DEVICES: Unanticipated adverse device effect, deviation from the protocol to protect the life of a subject in an emergency, or any use of the device without obtaining informed consent

**2. Briefly describe problem, event, or injury:** *When appropriate include date of event, date of discovery, whether the event is resolved, and whether the participant remains on study.*

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**3. Risk:** Does this problem or event suggest that there is a meaningful change in the risk/benefit profile of the study for participants who are currently enrolled in the study?

- No     Yes

**4. Consent:** Should the protocol and/or informed consent document be revised to discuss the problem or event?

- No     Yes

**5. Statement of surgeon:** *I have personally reviewed this report and agree with the above assessment.*

---

Date (mm/dd/yyyy)  /  / 20

Signature

Site ID: Subject ID: Review date:  /  / Reviewed by (certification no.): **Teen-LABS (AE) Study Related Adverse Event Form**Please PRINT NEATLY and complete this form in blue or black INK. Mark response boxes like this: 

Date of onset (mm/dd/yy)	Activity (Code) 10=400 meter 20=Stepwatch 30=Environment 40=Phlebotomy 50=Phys. Measure 60=Other Study Activity	Event (Code) See codes on back	Relationship to study  0=not related 1=possibly related 2=probably related 3=definitely related 4=indeterminate	Was this event unantic- ipated?	Severity  1=mild 2=moderate 3=severe 4=life threatening 5=death	Action taken  1=none 2=out-patient eval 3=hospitalization 4=other	Outcome date (mm/dd/yy)	Outcome status  1=resolved 2=continuing 3=controlled 4=death
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> <i>If other (60), specify:</i>	<input type="text"/> <i>If other (99), specify:</i>	<input type="text"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="text"/>	<input type="text"/> <i>If other (4), specify:</i>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> <i>If other (60), specify:</i>	<input type="text"/> <i>If other (99), specify:</i>	<input type="text"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="text"/>	<input type="text"/> <i>If other (4), specify:</i>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> <i>If other (60), specify:</i>	<input type="text"/> <i>If other (99), specify:</i>	<input type="text"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="text"/>	<input type="text"/> <i>If other (4), specify:</i>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>

Statement of PI: ***I have personally reviewed this report and agree with the above assessment.***

Signature \_\_\_\_\_

Date (mm/dd/yy)  /  /

**EVENT CODES:**

400 Meter Corridor Walk (Activity Code 10)

- 1 = angina, chest pain, tightness, or pressure
- 2 = trouble breathing, shortness of breath, wheezing, or dyspnea
- 3 = MI
- 4 = stroke
- 5 = lightheaded or dizzy
- 6 = loss of consciousness
- 7 = back pain
- 8 = hip pain
- 9 = knee pain
- 10 = calf pain, leg cramps
- 11 = foot pain
- 12 = numbness or tingling in legs or feet
- 99 = other, specify

Environmental Related (Activity Code 30)

- 1 = skin or peripheral nerve pressure injury (from too small chair, etc.)
- 2 = physical injury occurring during research visit (e.g. fall walking during visit)
- 3 = physical injury occurring to/from research visit (e.g. fall getting out of car)
- 4 = staff injury (e.g. coordinator injured while transporting study equipment)
- 99 = other, specify

Stepwatch Monitor (Activity Code 20)

- 1 = skin or peripheral nerve pressure injury (from band/monitor)
- 2 = back pain (from bending over to put on/remove monitor)
- 99 = other, specify

Phlebotomy Related (Activity Code 40)

- 1 = temporary discomfort or bruising
- 2 = infection at the skin puncture site
- 3 = fainting
- 99 = other, specify

Physical Measures Related (Activity Code 50)

- 1 = numbness and/or tingling during use of equipment (e.g. while BP cuff is inflated) but goes away immediately after equipment is removed
- 2 = numbness and/or tingling that persists after equipment is removed
- 3 = skin bruising
- 99 = other, specify

Other (Activity Code 60)

- 1 = breach of confidentiality
- 2 = referred to psychology
- 99 = other, specify

***NOTE:** This list is not all inclusive and the recording of an adverse event remains at the discretion of the investigator. A symptom or condition that is present but does not fit one of these levels may still be recorded as an adverse event.*

**DEFINITIONS:**

Definition of Unanticipated Event

Unanticipated adverse events are those not described in the informed consent document.

Severity Definitions

- Mild: Awareness of sign or symptom, but easily tolerated.
- Moderate: Discomfort sufficient to cause interference with normal activities.
- Severe: Incapacitating, with inability to perform normal activities.
- Life-threatening: Imminent peril of loss of life.
- Death: Death has occurred.

Relatedness to the Study

- Not related: Indisputably not related to any of the categories.
- Possibly related: Unlikely but uncertain as to whether the event is related to the category.
- Probably related: Likely but uncertain as to whether the event is related to the category.
- Definitely related: Indisputably related to any of the categories.
- Indeterminate: Complete lack in clarity or judgement as to whether the event is related to the category.

Outcome Status

- Resolved: Patient returned to previous health status with no subsequent problems.
- Continuing: Patient has not yet returned to previous health status and continues to be followed for the AE.
- Controlled: Event is present, but is controlled.
- Death: Death has occurred.

	Site ID: <input type="text"/>	Subject ID: <input type="text"/>	Reviewed by (certification no.): <input type="text"/>	
<b>For coordinator use only.</b>			Review date: <input type="text"/>	<input type="text"/>

### Teen-LABS (MRF) Mortality Report Form

**Form completion date:**  /  /  (mm/dd/yyyy)    **Completed by (certification no.):**

Please PRINT NEATLY and complete this form in blue or black INK. Mark response boxes like this:

*Supplied by the DCC:*

Date of death:  /  /       Date of Bariatric Surgery:  /  /

**1. Cause of Death (mark only one):**

- |   |  |
|---|--|
| <input type="checkbox"/> Bleeding                           | <input type="checkbox"/> Evisceration                        |
| <input type="checkbox"/> Sepsis from anastomotic leak       | <input type="checkbox"/> Pneumonia                           |
| <input type="checkbox"/> Sepsis from other abdominal source | <input type="checkbox"/> Respiratory failure, including ARDS |
| <input type="checkbox"/> Pulmonary embolus                  | <input type="checkbox"/> Accident → <i>end questionnaire</i> |
| <input type="checkbox"/> Cardiac failure                    | <input type="checkbox"/> Suicide → <i>end questionnaire</i>  |
| <input type="checkbox"/> Myocardial infarction              | <input type="checkbox"/> Other <i>specify:</i> _____         |
| <input type="checkbox"/> Cerebrovascular accident           | <input type="checkbox"/> Indeterminate                       |
| <input type="checkbox"/> Bowel obstruction                  |  |

**1.1 What is the Steering Committee Member's level of certainty for the above cause of death?**

- Definite
- Probable
- Indeterminate

**2. Did the patient die as a direct result of a complication occurring during, or within 24 hours after bariatric surgery?**

- No
- Yes

Site ID:

Subject ID:

For coordinator use only.

**Teen-LABS (MRF) Mortality Report Form**

3. Did the patient die as a direct result of a complication occurring during or after a procedure related to the bariatric surgery?

 No → *End; do not complete the rest of this form* Yes → Indeterminate3.1 Specify **procedure** directly related to the complication. (Mark "No" or "Yes" for each.)

<u>No</u>	<u>Yes</u>		<u>No</u>	<u>Yes</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Primary Bariatric Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Incisional hernia
<input type="checkbox"/>	<input type="checkbox"/>	Liver biopsy	<input type="checkbox"/>	<input type="checkbox"/>	Crural repair
<input type="checkbox"/>	<input type="checkbox"/>	Planned fiber optic intubation	<input type="checkbox"/>	<input type="checkbox"/>	Cholecystectomy
<input type="checkbox"/>	<input type="checkbox"/>	Gastrostomy	<input type="checkbox"/>	<input type="checkbox"/>	Lysis of extensive adhesions
<input type="checkbox"/>	<input type="checkbox"/>	Partial gastrectomy	<input type="checkbox"/>	<input type="checkbox"/>	Band replacement
<input type="checkbox"/>	<input type="checkbox"/>	Subtotal gastrectomy	<input type="checkbox"/>	<input type="checkbox"/>	Anastomotic revision
<input type="checkbox"/>	<input type="checkbox"/>	Truncal vagotomy		<input type="checkbox"/>	↳ <input type="checkbox"/> GJ <input type="checkbox"/> JJ <input type="checkbox"/> DJ
<input type="checkbox"/>	<input type="checkbox"/>	Partial vagotomy	<input type="checkbox"/>	<input type="checkbox"/>	Band/port revision
<input type="checkbox"/>	<input type="checkbox"/>	Endoscopy	<input type="checkbox"/>	<input type="checkbox"/>	Wound revision or evisceration
<input type="checkbox"/>	<input type="checkbox"/>	Placement of percutaneous drain	<input type="checkbox"/>	<input type="checkbox"/>	Tracheal reintubation
<input type="checkbox"/>	<input type="checkbox"/>	Panniculectomy	<input type="checkbox"/>	<input type="checkbox"/>	Tracheostomy
<input type="checkbox"/>	<input type="checkbox"/>	Unplanned splenectomy	<input type="checkbox"/>	<input type="checkbox"/>	Other, specify:
<input type="checkbox"/>	<input type="checkbox"/>	Umbilical hernia			

3.2 What is the Steering Committee Member's level of certainty for the above procedure(s)?

 Definite    Probable    Indeterminate3.3 Specify **complication** directly related to the death. (Mark "No" or "Yes" for each.)

<u>No</u>	<u>Yes</u>		<u>No</u>	<u>Yes</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Evisceration
<input type="checkbox"/>	<input type="checkbox"/>	Sepsis from anastomotic leak	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	<input type="checkbox"/>	Sepsis from other abdominal source	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory failure, including ARDS
<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary embolus	<input type="checkbox"/>	<input type="checkbox"/>	Staple line breakdown
<input type="checkbox"/>	<input type="checkbox"/>	Cardiac failure	<input type="checkbox"/>	<input type="checkbox"/>	Port or tube problems
<input type="checkbox"/>	<input type="checkbox"/>	Myocardial infarction	<input type="checkbox"/>	<input type="checkbox"/>	Gastric prolapse
<input type="checkbox"/>	<input type="checkbox"/>	Cerebrovascular accident	<input type="checkbox"/>	<input type="checkbox"/>	Esophageal motility disorder or dilation
<input type="checkbox"/>	<input type="checkbox"/>	Bowel obstruction	<input type="checkbox"/>	<input type="checkbox"/>	Gastroesophageal reflux
<input type="checkbox"/>	<input type="checkbox"/>	Incisional/ventral hernia	<input type="checkbox"/>	<input type="checkbox"/>	Persistent diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	Wound dehiscence	<input type="checkbox"/>	<input type="checkbox"/>	Dehydration
<input type="checkbox"/>	<input type="checkbox"/>	Acute cholecystitis	<input type="checkbox"/>	<input type="checkbox"/>	Acute renal failure
<input type="checkbox"/>	<input type="checkbox"/>	Anastomotic stricture	<input type="checkbox"/>	<input type="checkbox"/>	Liver failure
		↳ <input type="checkbox"/> GJ <input type="checkbox"/> JJ <input type="checkbox"/> DJ	<input type="checkbox"/>	<input type="checkbox"/>	Common bowel stones/cholangitis
<input type="checkbox"/>	<input type="checkbox"/>	Gastric band erosion	<input type="checkbox"/>	<input type="checkbox"/>	Other, specify:
<input type="checkbox"/>	<input type="checkbox"/>	Gastric band slippage			
<input type="checkbox"/>	<input type="checkbox"/>	Gastric band leakage	<input type="checkbox"/>	<input type="checkbox"/>	Indeterminate

3.4 What is the Steering Committee Member's level of certainty for the above complication(s)?

 Definite    Probable    Indeterminate

	Site ID: <input style="width:20px; height:20px; border: 1px solid black;" type="text"/> <input style="width:20px; height:20px; border: 1px solid black;" type="text"/>	Subject ID: <input style="width:20px; height:20px; border: 1px solid black;" type="text"/> <input style="width:20px; height:20px; border: 1px solid black;" type="text"/> <input style="width:20px; height:20px; border: 1px solid black;" type="text"/>	Reviewed by (certification no.): <input style="width:20px; height:20px; border: 1px solid black;" type="text"/> <input style="width:20px; height:20px; border: 1px solid black;" type="text"/>	
Visit: <input style="width:20px; height:20px; border: 1px solid black;" type="text"/>	<b>For coordinator use only.</b>		Review date: <input style="width:20px; height:20px; border: 1px solid black;" type="text"/> / <input style="width:20px; height:20px; border: 1px solid black;" type="text"/> / <input style="width:20px; height:20px; border: 1px solid black;" type="text"/>	

### Teen-LABS (BDI2S) BDI-II Scoring and Action Plan

**Form completion date:**  /  / 20 (mm/dd/yyyy)    **Completed by (certification no.):**

Please PRINT NEATLY and complete this form in blue or black INK. Mark response boxes like this:

**INSTRUCTIONS:**

*If any item is skipped, redirect the subject to the instructions at the top of the form. If after reviewing instructions, the subject refuses to answer Question 9, implement the BDI Scoring and Action Plan. If the subject refuses to answer any other question mark -4 ("Refused" and initial and date as indicator that instructions were reviewed with subject and participant chose NOT to answer specified item). Total the score using the highest possible score for the missing value of the question the participant refused to answer, and if greater than or equal to twenty, implement the BDI Action plan, if does not reach that threshold, no further action indicated.*

*If subject refuses to answer question 9 OR question 9 score is 2 or 3, implement appropriate action plan and complete the first checklist.*

*If question 9 is answered and the score is 0 or 1, but total BDI-II score is 20 or greater, implement appropriate action plan and complete the second checklist.*

**BDI Scoring**

Question 9 score: <input style="width:20px; height:20px; border: 1px solid black;" type="text"/>	Total from page 1: <input style="width:20px; height:20px; border: 1px solid black;" type="text"/>
	Total from page 2: <input style="width:20px; height:20px; border: 1px solid black;" type="text"/>
	<b>Total:</b> <input style="width:20px; height:20px; border: 1px solid black;" type="text"/>

**If Q9 score =2 or 3 OR subject refuses to answer  
ACTION PLAN - Coordinator Checklist**

	Done	Date (mm/dd/yy)	Time (24hr)	Certification # of Psychologist or PI
Paged the Site Psychologist or PI	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input style="width:20px; height:20px; border: 1px solid black;" type="text"/> / <input style="width:20px; height:20px; border: 1px solid black;" type="text"/> / <input style="width:20px; height:20px; border: 1px solid black;" type="text"/>	<input style="width:20px; height:20px; border: 1px solid black;" type="text"/> : <input style="width:20px; height:20px; border: 1px solid black;" type="text"/>	<input style="width:20px; height:20px; border: 1px solid black;" type="text"/>
Site Psychologist or PI verbally informed of situation	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input style="width:20px; height:20px; border: 1px solid black;" type="text"/> / <input style="width:20px; height:20px; border: 1px solid black;" type="text"/> / <input style="width:20px; height:20px; border: 1px solid black;" type="text"/>	<input style="width:20px; height:20px; border: 1px solid black;" type="text"/> : <input style="width:20px; height:20px; border: 1px solid black;" type="text"/>	<input style="width:20px; height:20px; border: 1px solid black;" type="text"/>

**If Total score >=20  
ACTION PLAN - Coordinator Checklist**

	Done	Date (mm/dd/yy)	Time (24hr)	Certification # of Psychologist
Site Psychologist contacted within 24 hours	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input style="width:20px; height:20px; border: 1px solid black;" type="text"/> / <input style="width:20px; height:20px; border: 1px solid black;" type="text"/> / <input style="width:20px; height:20px; border: 1px solid black;" type="text"/>	<input style="width:20px; height:20px; border: 1px solid black;" type="text"/> : <input style="width:20px; height:20px; border: 1px solid black;" type="text"/>	<input style="width:20px; height:20px; border: 1px solid black;" type="text"/>
Site Psychologist contacted family within 1 week and made referral	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input style="width:20px; height:20px; border: 1px solid black;" type="text"/> / <input style="width:20px; height:20px; border: 1px solid black;" type="text"/> / <input style="width:20px; height:20px; border: 1px solid black;" type="text"/>	<input style="width:20px; height:20px; border: 1px solid black;" type="text"/> : <input style="width:20px; height:20px; border: 1px solid black;" type="text"/>	<input style="width:20px; height:20px; border: 1px solid black;" type="text"/>

	Site ID: <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	Subject ID: <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	Reviewed by (certification no.): <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	
	Visit: <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	<b>For coordinator use only.</b>	Review date: <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> / <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> / <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	

### Teen-LABS (CDI) Caregiver Demographic Information

**Form completion date:**  /  / 20 (mm/dd/yyyy)

Please PRINT NEATLY and complete this form in blue or black INK. Mark response boxes like this:

**Directions:** Please mark one answer per question, unless otherwise indicated. This form is to be completed by the primary caregiver of the Teen LABS participant.

1. What is your gender?

- Male
- Female

2. What is your race (*mark all that apply*):

- |   |  |
|---|--|
| <input type="checkbox"/> White or Caucasian               | <input type="checkbox"/> Native Hawaiian or other Pacific Islander |
| <input type="checkbox"/> Black or African-American        | <input type="checkbox"/> Other <i>specify:</i> _____               |
| <input type="checkbox"/> Asian                            | <input type="checkbox"/> Unknown                                   |
| <input type="checkbox"/> American Indian or Alaska Native |  |

3. Are you of Hispanic or Latino origin or decent?

- No
- Yes
- Unknown

4. What is your age?  years old

5. How are you related to the study participant? I am his/her:

- |  |  |
|--|--|
| <input type="checkbox"/> Mother                      | <input type="checkbox"/> Father              |
| <input type="checkbox"/> Step-mother                 | <input type="checkbox"/> Step-father         |
| <input type="checkbox"/> Grandmother                 | <input type="checkbox"/> Grandfather         |
| <input type="checkbox"/> Aunt                        | <input type="checkbox"/> Uncle               |
| <input type="checkbox"/> Female legal guardian       | <input type="checkbox"/> Male legal guardian |
| <input type="checkbox"/> Other <i>specify:</i> _____ |  |

6. What is your current marital status?

- Single
- Married
- Living with partner
- Separated
- Divorced
- Widowed

**Teen-LABS (CDI) Caregiver Demographic Information**

7. What is the highest education level that you completed?

- Less than high school
- Some high school (grades 9-12, no diploma or GED)
- Some home-schooling (grades 9-12, no diploma or GED)
- General Equivalency Degree (GED)
- Graduated from high school
- 1 to 2 years of college, no degree yet
- 3 or more years of college, no degree yet
- Graduated from a 2-year college, business or vocational school, or got an Associates degree
- Graduated from a college university and obtained a Bachelor's degree (BS, BA)
- Some graduate school courses
- Master's degree
- Professional degree: Ph.D., Psy.D., Ed.D. M.D., DDS, LLB, LLD, JD etc.

8. Have you ever been employed for pay?

- No     Yes →

8.1 What is the primary occupation you have had for most of you working life? Since many people have more than one job at a given time, we would like to know about the job that is/was your primary source of income.

Job title: \_\_\_\_\_

9. What is your current employment status?

- |  |   |
|--|---|
| <input type="checkbox"/> Full-time (35 or more hours per week) for pay | <input type="checkbox"/> Leave of Absense             |
| <input type="checkbox"/> Part-time for pay                             | <input type="checkbox"/> Unemployed                   |
| <input type="checkbox"/> Homemaker                                     | <input type="checkbox"/> Retired                      |
| <input type="checkbox"/> Disabled                                      | <input type="checkbox"/> Other <i>specify</i> : _____ |

10. Is there another adult caregiver living in your home?

- No     Yes →

↓  
Skip to  
question 12  
on page 4

10.1 What is their relationship to you and/or the study participant?

<input type="checkbox"/> Husband/Participant's biological father	<input type="checkbox"/> My partner (boyfriend/girlfriend/fiance)
<input type="checkbox"/> Wife/Participant's biological mother	<input type="checkbox"/> Participant's grandfather
<input type="checkbox"/> Husband/Participant's step-father	<input type="checkbox"/> Participant's grandmother
<input type="checkbox"/> Wife/Participant's step-mother	<input type="checkbox"/> Other, specify: _____

Site ID:

Subject ID:

Visit:

For coordinator use only.

### Teen-LABS (CDI) Caregiver Demographic Information

11. Does this person share household expenses with you?

No  Yes →

11.1. What is his/her gender?

Male  Female

11.2. What is his/her race (*mark all that apply*):

White or Caucasian  Native Hawaiian or other Pacific Islander

Black or African-American  Other *specify*: \_\_\_\_\_

Asian

Unknown \_\_\_\_\_

American Indian or Alaska Native

11.3. Is he/she of Hispanic or Latino origin or decent?

No  Yes  Unknown

11.4 What is his/her age? \_\_\_\_\_ *years old*

11.5. What is the highest education level that this other caregiver has completed?

Less than high school

Some high school (grades 9-12, no diploma or GED)

Some home-schooling (grades 9-12, no diploma or GED)

General Equivalency Degree (GED)

Graduated from high school

1 to 2 years of college, no degree yet

3 or more years of college, no degree yet

Graduated from a 2-year college, business or vocational school, or got an Associates degree

Graduated from a college university and obtained a Bachelor's degree (BS, BA)

Some graduate school courses

Master's degree

Professional degree: Ph.D., Psy.D., Ed.D. M.D., DDS, LLB, LLD, JD etc.

11.6 Has this person ever been employed for pay?

No  Yes →

11.6.1 What is the primary occupation he/she has had for most of his/her working life? Since many people have more than one job at a given time, we would like to know about the job that is/was his/her primary source of income.

Job title: \_\_\_\_\_

11.7. What is his/her current employment status?

Full-time (35 or more hours per week) for pay

Leave of Absense

Part-time for pay

Unemployed

Homemaker

Retired

Disabled

Other, specify: \_\_\_\_\_

Site ID:    
 Subject ID:

Visit:

**For coordinator use only.**

**Teen-LABS (CDI) Caregiver Demographic Information**

12. How many people live in the same house as you do? Please include yourself in this count.

Number of adults (aged 18 or over):   
 Number of children and teens under 18 years old:

13. Which of the categories below represents your Annual Household Income before taxes?

- Less than \$5,000       \$50,000 - \$74,999
- \$5,000 - \$14,999       \$75,000 - \$99,999
- \$15,000 - \$24,999       \$100,000 - \$199,999
- \$25,000 - \$49,999       \$200,000 or more

14. Which of the categories below represents your Annual Personal Income before taxes?

- Less than \$5,000       \$50,000 - \$74,999
- \$5,000 - \$14,999       \$75,000 - \$99,999
- \$15,000 - \$24,999       \$100,000 - \$199,999
- \$25,000 - \$49,999       \$200,000 or more

15. Do you have medical insurance?

No     Yes →

15.1 Is the patient covered by your insurance?

No     Yes

15.2 Do you know what type of insurance you have?

No     Yes →

15.2. 1 What type of medical insurance do you have?  
*Mark "No" or "Yes" to each:*

No	Yes	
<input type="checkbox"/>	<input type="checkbox"/>	Medicaid HMO
<input type="checkbox"/>	<input type="checkbox"/>	Medicaid not HMO
<input type="checkbox"/>	<input type="checkbox"/>	Medicare HMO
<input type="checkbox"/>	<input type="checkbox"/>	Medicaid Traditional
<input type="checkbox"/>	<input type="checkbox"/>	Tricare (Military)
<input type="checkbox"/>	<input type="checkbox"/>	Private Insurance HMO
<input type="checkbox"/>	<input type="checkbox"/>	Private Insurance not HMO
<input type="checkbox"/>	<input type="checkbox"/>	Other Health Insurance, specify:

**PLEASE DO NOT FILL OUT THIS SECTION**  
**THIS IS TO BE COMPLETED ONLY BY A TEEN-LABS COORDINATOR**

**Certification number:**

	<b>Height</b>	<b>Weight</b>	<b>Bariatric surgery?</b>	<b>When? (mm/dd/yy)</b>
<b>Primary caregiver:</b>	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> cm	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> kg	<input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="text"/> / <input type="text"/> / <input type="text"/>
<b>Secondary caregiver:</b>	<input type="checkbox"/> N/A <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> cm	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> kg	<input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="text"/> / <input type="text"/> / <input type="text"/>

	Site ID: <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	Subject ID: <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	Reviewed by (certification no.): <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>
Visit: <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	<b>For coordinator use only.</b>		Review date: <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> / <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> / <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>

### Teen-LABS (SWH) School and Work History

**Form completion date:**  /  /  20   (mm/dd/yyyy)

Please PRINT NEATLY and complete this form in blue or black INK. Mark response boxes like this:

1. What is your current marital status?

- Single
- Engaged
- Married → specify when:  /  /
- Divorced → specify when:  /  /
- Separated → specify when:  /  /
- Widowed → specify when:  /  /
- Remarried → specify when:  /  /

2. What is your current living situation? Select all that apply to you:

- Live with parent(s)
- Live alone
- Live with other relatives
- Live with friends in a house or apartment
- Live in a college dorm
- Live with husband/wife
- Live with boyfriend/girlfriend
- Live in a treatment center, hospital, or special home
- Other, specify:

3. Have you lived somewhere other than this in the **past 12 months**?

- No    Yes →
- 3.1 Mark **all** living situations that applied to you in the **past 12 months**:

  - Live with parent(s)
  - Live alone
  - Live with other relatives
  - Live with friends in a house or apartment
  - Live in a college dorm
  - Live with husband/wife
  - Live with boyfriend/girlfriend
  - Live in a treatment center, hospital, or special home
  - Other, specify:



Site ID:

Subject ID:

Visit:

### Teen-LABS (SWH) School and Work History

5. What is the highest education level that you completed?

- Less than high school
- Some high school (grades 9-12, no diploma or GED)
- Some home-schooling (grades 9-12, no diploma or GED)
- General Equivalency Degree (GED)
- Graduated from high school
- 1 to 2 years of college, no degree yet
- 3 or more years of college, no degree yet
- Graduated from a 2-year college, business or vocational school, or got an Associates degree
- Graduated from a college university and obtained a Bachelor's degree (BS, BA)
- Some graduate school courses
- Master's degree
- Professional degree: Ph.D., Psy.D., Ed.D. M.D., DDS, LLB, LLD, JD etc.

6. What kind of school are you enrolled in currently, if any? If it is now summer, please respond based on your plans for the upcoming fall. Mark only one.

- Not attending any school
- Home schooled (no diploma or GED) → 

6.1 What grade are you currently in (or will be in if it is now summer)? <input type="text"/> <input type="text"/> th grade
--
- Attending junior high or high school → 

6.1 What grade are you currently in (or will be in if it is now summer)? <input type="text"/> <input type="text"/> th grade
--
- Attending post-high school technical, art, or business school → *Skip to question 8 on the next page*
- Attending college or university → *Skip to question 8 on the next page*
- Attending graduate school → *Skip to question 8 on the next page*

Site ID:    Subject ID:

Visit:

**Teen-LABS (SWH) School and Work History**

7. Are you attending a junior high or high school at the present time? (If it is now summer, but you will be attending in the fall, respond "Yes.")

- NO, I am not attending a junior high or high school       YES, I am currently attending a junior high or high school

↓

7.1 Why aren't you attending junior high or high school? (Please mark the one best answer.)

I already graduated from high school/got a GED  
 My health makes it hard for me to go, so I just don't go  
 I have officially dropped out of school  
 I am home schooled

↳ 7.1.1 Why are you home schooled? (Mark "No" or "Yes" to each.)

<u>No</u>	<u>Yes</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Better learning environment at home
<input type="checkbox"/>	<input type="checkbox"/>	I was suspended/expelled from school
<input type="checkbox"/>	<input type="checkbox"/>	Teasing and social situation
<input type="checkbox"/>	<input type="checkbox"/>	My health status makes it hard to attend
<input type="checkbox"/>	<input type="checkbox"/>	Too much walking for me
<input type="checkbox"/>	<input type="checkbox"/>	I have difficulty fitting into school desks
<input type="checkbox"/>	<input type="checkbox"/>	Other reason

↳ specify:

7.1.2 Overall, how would you rate your current home-schooling performance?

Excellent (mostly A's)  
 Very Good (mostly B's)  
 Average (mostly C's)  
 Below Average (mostly D's)  
 Failing (mostly F's)

↓

7.2 What is your school day like? (Please mark the one best answer.)

I attend during regular school hours, like everyone else  
 I attend but have a shortened day

↳ 7.2.1 Please explain why:

7.3 Overall, how would you rate your current school performance?

Excellent (mostly A's)  
 Very Good (mostly B's)  
 Average (mostly C's)  
 Below Average (mostly D's)  
 Failing (mostly F's)

7.4 Have you done any of the following? (Mark "No" or "Yes" to each.)

<u>No</u>	<u>Yes</u>	
<input type="checkbox"/>	<input type="checkbox"/>	I am absent from school frequently
<input type="checkbox"/>	<input type="checkbox"/>	I am often late for school
<input type="checkbox"/>	<input type="checkbox"/>	I have been suspended from school
<input type="checkbox"/>	<input type="checkbox"/>	I have been expelled (kicked out of) school

**School History**

8. Did you ever...? (Mark "No" or "Yes" to each.)

<u>No</u>	<u>Yes</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Receive junior high or high school honors or awards
<input type="checkbox"/>	<input type="checkbox"/>	Repeat a grade in elementary school
<input type="checkbox"/>	<input type="checkbox"/>	Repeat a grade in middle school/junior high school
<input type="checkbox"/>	<input type="checkbox"/>	Repeat a grade in high school
<input type="checkbox"/>	<input type="checkbox"/>	Home school
<input type="checkbox"/>	<input type="checkbox"/>	Participate in school clubs or activities (student government, yearbook, music-related, etc.)
<input type="checkbox"/>	<input type="checkbox"/>	Participate on a school-based sports team
<input type="checkbox"/>	<input type="checkbox"/>	Receive educational assistance due to a learning disability

↳ Please describe:

	Site ID: <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	Subject ID: <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	
	Visit: <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>		

**Teen-LABS (SWH) School and Work History**

**Work**

9. As of today, are you working for pay? (Mark the one best response.)
- Yes, I'm working full-time for pay (35 or more hours/week) → *Skip to question 12*
  - Yes, I'm working part-time for pay (less than 35 hours/week) → *Skip to question 12*
  - Yes, I'm working a summer job for pay (job will end when school in session) → *Skip to question 12*
  - No, I am unemployed and looking for work
  - No, I am unemployed but NOT looking for work
10. Have you held a paying job in the past? Do not include chores you might do for extra money.
- Yes, I have worked full-time for pay (35 or more hours/week)
  - Yes, I have worked part-time for pay (less than 35 hours/week)
  - Yes, I have held a summer job for pay
  - No, I have never held a paying job → *Skip to question 12*
11. If you have held a paying job in the past, whether full-time or part-time, why are you no longer working?
- It was a summer job only
  - I was laid off because the company cut back or closed
  - I was fired
  - I quit or resigned
12. As of today, how do you pay for your day-to-day living expenses (e.g., food, shelter, entertainment)? *Mark "No" or "Yes" to each.*
- | <u>No</u>                | <u>Yes</u>               |  | <u>No</u>                | <u>Yes</u>               |              |
|--------------------------|--------------------------|--|--------------------------|--------------------------|--------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Parents  | <input type="checkbox"/> | <input type="checkbox"/> | Friend       |
| <input type="checkbox"/> | <input type="checkbox"/> | My own job                                       | <input type="checkbox"/> | <input type="checkbox"/> | Husband/Wife |
| <input type="checkbox"/> | <input type="checkbox"/> | Government funds (e.g. Social Security, Welfare) | <input type="checkbox"/> | <input type="checkbox"/> | Other        |
- ↳ Please specify:
13. During the **past 12 months**, have you done any other work on a regular basis to earn extra money? *Mark "No" or "Yes" to each.* For each type of work you have done, specify how many hours a week you would typically work.
- | <u>No</u>                | <u>Yes</u>               |  | <i>If yes</i>  |
|--------------------------|--------------------------|--|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Babysitting  | → <input style="width: 20px; height: 20px; border: 1px solid black;"/> <input style="width: 20px; height: 20px; border: 1px solid black;"/> hours/week |
| <input type="checkbox"/> | <input type="checkbox"/> | Yard care  | → <input style="width: 20px; height: 20px; border: 1px solid black;"/> <input style="width: 20px; height: 20px; border: 1px solid black;"/> hours/week |
| <input type="checkbox"/> | <input type="checkbox"/> | Cleaning house   | → <input style="width: 20px; height: 20px; border: 1px solid black;"/> <input style="width: 20px; height: 20px; border: 1px solid black;"/> hours/week |
| <input type="checkbox"/> | <input type="checkbox"/> | Farmwork   | → <input style="width: 20px; height: 20px; border: 1px solid black;"/> <input style="width: 20px; height: 20px; border: 1px solid black;"/> hours/week |
| <input type="checkbox"/> | <input type="checkbox"/> | Other, list one task per line:                           |  |
|                          | ↳ 1.                     | <input style="width: 150px; height: 20px;" type="text"/> | → <input style="width: 20px; height: 20px; border: 1px solid black;"/> <input style="width: 20px; height: 20px; border: 1px solid black;"/> hours/week |
|                          | 2.                       | <input style="width: 150px; height: 20px;" type="text"/> | → <input style="width: 20px; height: 20px; border: 1px solid black;"/> <input style="width: 20px; height: 20px; border: 1px solid black;"/> hours/week |
|                          | 3.                       | <input style="width: 150px; height: 20px;" type="text"/> | → <input style="width: 20px; height: 20px; border: 1px solid black;"/> <input style="width: 20px; height: 20px; border: 1px solid black;"/> hours/week |

Site ID:

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Visit:

### Teen-LABS (SWH) School and Work History

14. How many people live in the same house as you do? Please include yourself in this count.

Number of adults (aged 18 or over):   Number of children and teens under 18 years old:

15. Which of the categories below represents your Annual Household Income before taxes?

- Don't know
- \$50,000 - \$74,999
- Less than \$5,000
- \$75,000 - \$99,999
- \$5,000 - \$14,999
- \$100,000 - \$199,999
- \$15,000 - \$24,999
- \$200,000 or more
- \$25,000 - \$49,999

16. Which of the categories below represents your Annual Personal Income before taxes?

- Don't know
- \$50,000 - \$74,999
- Less than \$5,000
- \$75,000 - \$99,999
- \$5,000 - \$14,999
- \$100,000 - \$199,999
- \$15,000 - \$24,999
- \$200,000 or more
- \$25,000 - \$49,999

17. Do you have medical insurance?

- Don't know
- No
- Yes →

17.1 Please select one of the following:

- I am covered by my parent's/caregiver's insurance
- I am covered by my spouse's insurance
- I am covered by my own insurance

17.2 Do you know what type of insurance you are covered by?

- No
- Yes →

17.2.1 What type of medical insurance are you covered by?

Mark "No" or "Yes" to each:

No   Yes

- Medicaid HMO
- Medicaid not HMO
- Medicare HMO
- Medicaid Traditional
- Tricare (Military)
- Private Insurance HMO
- Private Insurance not HMO
- Other Health Insurance, specify:

17.3 Does your medical insurance pay for your clinical bariatric surgical follow-up visits?

- Don't know
- No
- Yes

**Teen-LABS (BB) Behavior Baseline**

Form completion date:   /   /     (mm/dd/yyyy)

Please PRINT NEATLY and complete this form in blue or black INK. Mark response boxes like this: ☒

**Directions:** Please complete the following questions by marking the appropriate response or filling in the blank.

1. Were you advised or required by your surgeon or member of the surgery team to lose weight in preparation for your obesity surgery?

No  Yes →

1.1 How much weight were you advised or required to lose?

lbs (or)  "no amount specified"

↓  
Skip to question 2

2. Were you advised or required by your surgeon or member of the surgery team to start a special diet in preparation for your obesity surgery?

No  Yes →

2.1 Was this special diet (mark "No" or "Yes" for each)...

	No	Yes
a. very low calorie (less than 800 cal/day), for example using a commercial weight loss product like Optifast or Nutrifast, or eating smaller portions?	<input type="checkbox"/>	<input type="checkbox"/>
b. high protein/low carbohydrate (e.g., Atkins)?	<input type="checkbox"/>	<input type="checkbox"/>
c. ground or pureed foods?	<input type="checkbox"/>	<input type="checkbox"/>
d. other special diet not mentioned above?	<input type="checkbox"/>	<input type="checkbox"/>

specify:

2.2 Did you follow the special diet?

No  Rarely  Occasionally  Usually  Always

↓  
Skip to question 3

3. Have you lost or gained any weight in the **past 3 months**?

No  Don't know  Yes →

If Yes, mark "No" or "Yes" for each.

	No	Yes	
3.1 Lost weight	<input type="checkbox"/>	<input type="checkbox"/>	→ a. How much? <input type="text"/> lbs
			b. Were you purposefully trying to lose weight by eating less?
			<input type="checkbox"/> No <input type="checkbox"/> Yes
3.2 Gained weight	<input type="checkbox"/>	<input type="checkbox"/>	→ a. How much? <input type="text"/> lbs

↓ ↓  
Skip to the next page

Site ID:

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### Teen-LABS (BB) Behavior Baseline

**Directions:** The following questions<sup>1</sup> ask you to provide what you consider your dream weight, happy weight, acceptable weight, and unhappy weight. Please provide a number (in pounds) that corresponds to the four descriptions below.

1. The first weight is your dream weight, a weight that you would choose if you could weigh whatever you wanted. What is this weight?

Dream Weight:  lbs

2. The second weight is not as ideal as the first one. It is a weight, however, that you would be happy to achieve. What is this weight?

Happy Weight:  lbs

3. The third weight is one that you would not be particularly happy with, but one that you could accept, since it would be less than your current weight. What is this weight?

Acceptable Weight:  lbs

4. The fourth weight is one that is less than your current weight, but one that you could not view as successful in any way. You would be disappointed if this was your final weight after surgery. What is this weight?

Disappointed Weight:  lbs

*The next set of questions asks about weight control practices.*

1. Do you have access to a scale to weigh yourself?

No  Yes →



*Skip to  
question on  
next page*

1.1 How often do you weigh yourself? (Mark one answer only.)

- Never
- About once a year or less
- Every couple months
- Every month
- Every week
- Every day
- More than once per day

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**Teen-LABS (BB) Behavior Baseline**

**Directions:** The following questions<sup>2</sup> ask about your weight control practices. Please indicate whether you **ever** did any of the activities listed below **in order to control your weight prior to coming to this program** to consider having bariatric surgery.

- If you ever did an activity in order to control your weight, mark "Yes" and follow the arrow to complete the next column.

Indicate whether you did the activity in the **6 months prior to coming to this program** to consider having bariatric surgery.

If so, specify **how many weeks** during those **6 months prior to this program** you did the activity. Please note that there are approximately 26 weeks in 6 months.

- If you **never** did an activity in order to control your weight, mark "No" and go to the next item.

For weight control, have you ever...	Did you do this in the <b>6 months prior to coming to this program</b> ?		
	No	Yes	How many weeks?
1. counted fat grams? <input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/>	<input type="checkbox"/>	→ <input type="text"/>
2. decreased fat intake? <input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/>	<input type="checkbox"/>	→ <input type="text"/>
3. reduced the number of calories you eat? <input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/>	<input type="checkbox"/>	→ <input type="text"/>
4. used a very low calorie diet? <input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/>	<input type="checkbox"/>	→ <input type="text"/>
5. cut out between-meal-snacking? <input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/>	<input type="checkbox"/>	→ <input type="text"/>
6. eaten fewer high carbohydrate foods like bread or potatoes? <input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/>	<input type="checkbox"/>	→ <input type="text"/>
7. eaten special low calorie diet foods? <input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/>	<input type="checkbox"/>	→ <input type="text"/>
8. eaten or drank meal replacements? <input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/>	<input type="checkbox"/>	→ <input type="text"/>
9. increased fruits and vegetables? <input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/>	<input type="checkbox"/>	→ <input type="text"/>
10. cut out non-diet soda pop or other sugar-sweetened beverages? <input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/>	<input type="checkbox"/>	→ <input type="text"/>
11. chewed and spit out food? <input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/>	<input type="checkbox"/>	→ <input type="text"/>
12. drank fewer alcoholic beverages for weight control? <input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/>	<input type="checkbox"/>	→ <input type="text"/>
13. smoked cigarettes for weight control? <input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/>	<input type="checkbox"/>	→ <input type="text"/>
14. induced vomiting for weight control? <input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/>	<input type="checkbox"/>	→ <input type="text"/>
15. recorded what you eat daily? <input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/>	<input type="checkbox"/>	→ <input type="text"/>
16. kept a graph of your weight? <input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/>	<input type="checkbox"/>	→ <input type="text"/>
17. increased your exercise level? <input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/>	<input type="checkbox"/>	→ <input type="text"/>
18. used home exercise equipment? <input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/>	<input type="checkbox"/>	→ <input type="text"/>
19. recorded your exercise daily? <input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/>	<input type="checkbox"/>	→ <input type="text"/>
20. participated in group exercise classes? <input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/>	<input type="checkbox"/>	→ <input type="text"/>
21. participated in a support/self help group? (e.g. <i>Weight Watchers, TOPS</i> ) <input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/>	<input type="checkbox"/>	→ <input type="text"/>
22. accessed a discussion group, bulletin board, or chat room on the internet? <input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/>	<input type="checkbox"/>	→ <input type="text"/>
23. used hypnosis for weight control? <input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/>	<input type="checkbox"/>	→ <input type="text"/>

Site ID: Subject ID: 

For coordinator use only.

## Teen-LABS (BB) Behavior Baseline

Continued from previous page

For weight control, have you ever...	Did you do this in the <b>6 months</b> prior to coming to this program?		
	No	Yes	How many weeks?
24. used laxatives for weight control? <input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/>	<input type="checkbox"/>	→ <input type="text"/>
25. used any prescription medication? (e.g., Wellbutrin, Xenical, Medridia, Trexan, Ionamin, Adipex, Phentermine plus Fenfluramine, Topamax, Pondimin, Redux, Dexedrine) <input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/>	<input type="checkbox"/>	→ <input type="text"/>
26. used any dietary supplement or non-prescription medication? <input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/>	<input type="checkbox"/>	→ <input type="text"/>

**Directions:** The following questions ask about whether you have **ever** seen any of the professionals listed below **in order to control your weight prior to coming to this program** to consider having bariatric surgery.

- If you ever saw one of the professionals listed below in order to control your weight, mark "Yes" and follow the arrow to complete the next column indicating **how many times** you saw the professional in the **6 months prior to coming to this program** to consider having bariatric surgery.

- If you never saw the professional in order to control your weight, mark "No" and go to the next item.

For weight control, have you ever...	How many times in the <b>6 months</b> prior to coming to this program?				
	0 times	1 to 5 times	6 to 10 times	11 to 20 times	more than 20 times
1. seen a counselor/mental health professional? <input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. seen a nutritionist/dietitian? <input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. seen a personal trainer or exercise specialist? <input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The next set of questions asks about your eating habits during a usual or normal week.

1. Thinking about your **usual or normal week**...

a. How many days out of the **7-day week** do you eat breakfast?

 days/week

b. How many days out of the **7-day week** do you eat lunch/brunch?

 days/week

c. How many days out of the **7-day week** do you eat dinner?

 days/week

d. Counting all meals and any snacks you may have, **how many times a day** do you eat? (Mark box if more than 10 times/day.)

 times/day

 more than 10 times a day

2. How many days a week do you **eat out** at...

Breakfast

Brunch/Lunch

Dinner

a. Fast food restaurants:  days/week

 days/week

 days/week

b. Other types of restaurants:  days/week

 days/week

 days/week

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### Teen-LABS (BB) Behavior Baseline

The next question asks about your lifelong eating habits.

1. Have you **ever** had times when you eat continuously during the day or parts of the day without planning what and how much you would eat?

No  Yes →

1.1 Did you experience a loss of control, that is, you felt like you could not control your eating?

No  Yes



Skip to question 2

The next questions<sup>3</sup> ask about your eating habits over the **6 months prior to coming to this program** to consider bariatric surgery.

2. During the **6 months prior to coming to this program**, have you had times when you eat continuously during the day or parts of the day without planning what and how much you would eat?

No  Yes →

2.1 Did you experience a loss of control, that is, you felt like you could not control your eating?

No  Yes



Skip to question 3

3. During the **6 months prior to coming to this program**, did you ever eat within any two-hour period what most people would regard as an unusually large amount of food?

No  Yes →

3.1 During the **6 months prior to coming to this program**, how often, on average, did you have times when you ate this way -- that is, large amounts of food **plus** the feeling that your eating was out of control? (There may have been some weeks when it was not present - just average those in.)

Less than one day a week     Two or three days a week     Nearly every day  
 One day a week     Four or five days a week



Skip to question 4

3.2 Did you **usually** have any of the following experiences during these occasions?

- a. Eating much more rapidly than usual.  No  Yes
- b. Eating until you felt uncomfortably full.  No  Yes
- c. Eating large amounts of food when you didn't feel physically hungry.  No  Yes
- d. Eating alone because you were embarrassed by how much you were eating.  No  Yes
- e. Feeling disgusted with yourself, depressed, or feeling very guilty after overeating.  No  Yes

3.3 During the **6 months prior to coming to this program**, when you overate how upset were you from overeating (eating more than you think is best for you)?

Not at all     Slightly     Moderately     Greatly     Extremely

4. In general, during the **6 months prior to coming to this program**, when you felt like your eating was out of control how upset were you by the feeling that you couldn't stop eating or control what or how much you were eating?

Not at all     Slightly     Moderately     Greatly     Extremely

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### Teen-LABS (BB) Behavior Baseline

5. During the **6 months prior to coming to this program**, how important has your weight or shape been in how you feel about or evaluate yourself as a person -- as compared to other aspects of your life, such as how you do at school, work, as a parent, or how you get along with other people?

- Weight and shape were **not very important**.
- Weight and shape **played a part** in how I felt about myself.
- Weight and shape **were among the main things** that affected how I felt about myself.
- Weight and shape **were the most important things** that affected how I felt about myself.

*This next set of questions asks about activities related to binge eating (consuming large amounts of food in a short period of time) over the 3 months prior to coming to this program to consider bariatric surgery.*

1. In the **3 months prior to coming to this program**, have you had any episodes of binge eating?

- No    Yes



*Skip to  
question 8  
on page 7*

2. During the **3 months prior to coming to this program**, did you ever make yourself vomit to avoid gaining weight after binge eating?

- No    Yes   →



*Skip to  
question 3*

2.1 How often, **on average**, was that?

- Less than once a week
- Once a week
- Two or three times a week
- Four or five times a week
- More than five times a week

3. During the **3 months prior to coming to this program**, did you ever take more than twice the recommended dose of laxatives in order to avoid gaining weight after binge eating?

- No    Yes   →



*Skip to  
question 4  
on page 7*

3.1 How often, **on average**, was that?

- Less than once a week
- Once a week
- Two or three times a week
- Four or five times a week
- More than five times a week

Site ID:

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For coordinator use only.

### Teen-LABS (BB) Behavior Baseline

4. During the **3 months prior to coming to this program**, did you ever take more than twice the recommended dose of diuretics (water pills) in order to avoid gaining weight after binge eating?

No  Yes →

↓  
*Skip to  
question 5*

4.1 How often, **on average**, was that?

- Less than once a week
- Once a week
- Two or three times a week
- Four or five times a week
- More than five times a week

5. During the **3 months prior to coming to this program**, did you ever fast (not eating anything at all for at least 24 hours) in order to avoid gaining weight after binge eating?

No  Yes →

↓  
*Skip to  
question 6*

5.1 How often, **on average**, was that?

- Less than once a week
- Once a week
- Two or three times a week
- Four or five times a week
- More than five times a week

6. During the **3 months prior to coming to this program**, did you ever exercise for more than an hour **specifically** in order to avoid gaining weight after binge eating?

No  Yes →

↓  
*Skip to  
question 7*

6.1 How often, **on average**, was that?

- Less than once a week
- Once a week
- Two or three times a week
- Four or five times a week
- More than five times a week

7. During the **3 months prior to coming to this program**, did you ever take twice the recommended dose of a diet pill in order to avoid gaining weight after binge eating?

No  Yes →

↓  
*Skip to  
question 8*

7.1 How often, **on average**, was that?

- Less than once a week
- Once a week
- Two or three times a week
- Four or five times a week
- More than five times a week

8. During the **3 months prior to coming to this program**, have you withheld your use of insulin to try to control your weight?

I do not use insulin  No  Yes

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### Teen-LABS (BB) Behavior Baseline

*This next set of questions<sup>4</sup> asks about how you have felt and how often you did various activities in the 3 months prior to coming to this program to consider bariatric surgery.*

1. During the **3 months prior to coming to this program**, on average, how many hours per day did you spend watching TV, using a computer, and/or playing video games?  
 None    1 hour or less    1 to 2 hours    2 to 4 hours    More than 4 hours
2. During the **3 months prior to coming to this program**, how much of your daily food intake did you consume after suppertime?  
 None    Up to a quarter    About half    More than half    Almost all
3. During the **3 months prior to coming to this program**, how hungry were you on a usual morning?  
 Not at all    A little    Somewhat    Moderately    Very
4. During the **3 months prior to coming to this program**, how often did you have trouble getting to sleep?  
 Never    Sometimes    About half the time    Usually    Always
5. Other than to use the bathroom, during the **3 months prior to coming to this program**, how often did you get up at least once in the middle of the night?  
 Never    Less than once a week    About once a week    More than once a week    Every night



*Skip to question 7*

6. During the **3 months prior to coming to this program**, when you got up in the middle of the night, how often did you snack?

Never → *Skip to question 7*

Sometimes \_\_\_\_\_

About half the time \_\_\_\_\_

Usually \_\_\_\_\_

Always \_\_\_\_\_



6.1 When you snacked in the middle of the night, how aware were you of your eating?

Not at all    A little    Somewhat    Very much    Completely

7. During the **3 months prior to coming to this program**, were you in an occupation involving night or evening shifts or other unusual time requirements that interfere with meals?

No    Yes

8. During the **3 months prior to coming to this program**, how often did you keep eating a meal even though you were not hungry any more?

Rarely or never    Occasionally (once per week)    Frequently (more than once per week)    Nearly every day

9. During the **3 months prior to coming to this program**, how often did you keep eating a meal even though you felt full?

Rarely or never    Occasionally (once per week)    Frequently (more than once per week)    Nearly every day

Site ID:

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**Teen-LABS (BB) Behavior Baseline***The next set of questions asks about tobacco use.*

1. Do you currently smoke cigarettes?

 No  Yes →1.1 On average, how many packs per day do you currently smoke?  packs/day*Note: Make sure you report how many PACKS per day you smoke.**20 cigarettes = 1 pack; 10 cigarettes = 1/2 pack = 0.5 pack; 5 cigarettes = 1/4 pack = 0.25 pack*

2. Do you currently use other forms of tobacco, such as cigars, cigarillos, chewing tobacco, snuff, dip, etc.?

 No  Yes →

2.1 On average, how often do you currently use other forms of tobacco?

 Less than monthly  Monthly  2 to 3 times/week  4 to 6 times/week  Daily*The next set of questions<sup>5</sup> asks about alcohol use in the past 12 months.*

1. How often do you have a drink containing alcohol?

 Never → *Skip to next page* Monthly or less Two to four times a month Two to three times per week Four or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

 1 or 2 drinks  3 or 4 drinks  5 or 6 drinks  7 to 9 drinks  10 or more drinks

3. How often do you have six or more drinks on one occasion?

 Never  Less than monthly  Monthly  Weekly (2 to 3 times/week)  Daily or almost daily (4 or more times/week)4. How often, during the past 12 months, have you found that you were not able to stop drinking once you had started? Never  Less than monthly  Monthly  Weekly (2 to 3 times/week)  Daily or almost daily (4 or more times/week)5. How often, during the past 12 months, have you failed to do what was normally expected from you because of drinking? Never  Less than monthly  Monthly  Weekly (2 to 3 times/week)  Daily or almost daily (4 or more times/week)6. How often, during the past 12 months, have you needed a first drink in the morning to get yourself going after a heavy drinking session? Never  Less than monthly  Monthly  Weekly (2 to 3 times/week)  Daily or almost daily (4 or more times/week)7. How often, during the past 12 months, have you had a feeling of guilt or remorse after drinking? Never  Less than monthly  Monthly  Weekly (2 to 3 times/week)  Daily or almost daily (4 or more times/week)8. How often, during the past 12 months, have you been unable to remember what happened the night before because you had been drinking? Never  Less than monthly  Monthly  Weekly (2 to 3 times/week)  Daily or almost daily (4 or more times/week)

9. Have you or someone else been injured as a result of your drinking?

 No  Yes, but not in the past 12 months  Yes, during the last year

10. Has a relative or friend, or doctor or other health worker been concerned about your drinking and suggested you cut down?

 No  Yes, but not in the past 12 months  Yes, during the last year

Site ID:

Subject ID:

**For coordinator use only.****Teen-LABS (BB) Behavior Baseline***The next set of questions asks about substance use in the past 12 months.***Directions:** Indicate your use of any of the substances listed below. *Note: All of your responses will remain confidential.*  
If you did not use a particular substance, mark "No" and go to the next item.1. In the **past 12 months**, other than as prescribed by a physician, have you used any of the following:

1.1 Opiates (such as codeine, morphine, heroin, etc.)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
1.2 Amphetamines (such as white crosses, speed, "meth")?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
1.3 Hallucinogens (such as LSD, mescaline)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
1.4 Inhalants (such as sniffing glue)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
1.5 Marijuana/hashish/pot?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
1.6 Cocaine/crack?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
1.7 PCP/Angel dust?	<input type="checkbox"/> No	<input type="checkbox"/> Yes

Acknowledgement of the following sources for questions contained on this form:

- Foster GD, Wadden TA, Vogt RA, Brewer G. What is a reasonable weight loss? Patients' expectations and evaluations of obesity treatment outcomes. *J Consult Clin Psychol.* 1997;65:79-85.
- Look AHEAD (Action For Health in Diabetes) Study and based in part on the following sources:  
Jeffery RW, French SA: Preventing weight gain in adults: The Pound of Prevention Study. *Am J Public Health* 1999;89:747-51.  
French SA, Jeffery RW, Murray D: Is dieting good for you? Prevalence, duration and associated weight and behaviour changes for specific weight loss strategies over four years in US adults. *Int J Obes* 1999;23:320-27.
- QEWPR© Spitzer RL, Yanovski SZ, Marcus MD. (HaPI Record). 1994; Pittsburgh PA: Behavioral Measurement Database Services (Producer). McLean, VA: BRS Search Service (Vendor).
- Nighttime Eating Phone Screen, Dr. James Mitchell, Neuropsychiatric Research Institute, Fargo, ND.
- Saunders JB, Aasland OG, Babor TF et al. Development of the alcohol use disorders identification test (AUDIT): WHO collaborative project on early detection of persons with harmful alcohol consumption – II. *Addiction* 1993, 88:791-803.

Site ID: Subject ID: Reviewed by (certification no.): **For coordinator use only.**Review date:  /  / **Teen-LABS (BU) Baseline Update Questionnaire****Form completion date:**  /  / 20 (mm/dd/yyyy)Please PRINT NEATLY and complete this form in blue or black INK. Mark response boxes like this: **Directions:** Please complete the following questions by marking the appropriate response or filling in the blank.

1. Were you advised or required by your surgeon or member of the surgery team to lose weight in preparation for your obesity surgery?

 No  Yes →

1.1 How much weight were you advised or required to lose?

 lbs (or)  "no amount specified"↓  
Skip to  
question 2

2. Were you advised or required by your surgeon or member of the surgery team to start a special diet in preparation for your obesity surgery?

 No  Yes →

2.1 Was this special diet (mark "No" or "Yes" for each)...

a. very low calorie (less than 800 cal/day), for example using a commercial weight loss product like Optifast or Nutrifast, or eating smaller portions?

No Yes 

b. high protein/low carbohydrate (e.g., Atkins)?

c. ground or pureed foods?

d. other special diet not mentioned above?

specify: \_\_\_\_\_

↓  
Skip to  
question 3

2.2 Did you follow the special diet?

 No  Rarely  Occasionally  Usually  Always3. Have you lost or gained any weight in the **past 3 months**? No  Don't know  Yes →↓ ↓  
Skip to the next page

If Yes, mark "No" or "Yes" for each.

No Yes3.1 Lost weight   →a. How much?  .  lbs

b. Were you purposefully trying to lose weight by eating less?

 No  Yes3.2 Gained weight   →a. How much?  .  lbs

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### Teen-LABS (BU) Baseline Update Questionnaire

**Directions:** The following questions\* ask you to provide what you consider your dream weight, happy weight, acceptable weight, and unhappy weight. Please provide a number (in pounds) that corresponds to the four descriptions below.

1. The first weight is your dream weight, a weight that you would choose if you could weigh whatever you wanted. What is this weight?

Dream Weight: \_\_\_\_\_ lbs

2. The second weight is not as ideal as the first one. It is a weight, however, that you would be happy to achieve. What is this weight?

Happy Weight: \_\_\_\_\_ lbs

3. The third weight is one that you would not be particularly happy with, but one that you could accept, since it would be less than your current weight. What is this weight?

Acceptable Weight: \_\_\_\_\_ lbs

4. The fourth weight is one that is less than your current weight, but one that you could not view as successful in any way. You would be disappointed if this was your final weight after surgery. What is this weight?

Disappointed Weight: \_\_\_\_\_ lbs

\*Source: Foster GD, Wadden TA, Vogt RA, Brewer G. What is a reasonable weight loss? Patients' expectations and evaluations of obesity treatment outcomes. J Consult Clin Psychol. 1997;65:79-85.

**Teen-LABS (BF) Behavior Follow-up**

**Form completion date:**   /   /     (mm/dd/yyyy)

Please PRINT NEATLY and complete this form in blue or black INK. Mark response boxes like this:

**Directions:** Answer all items as accurately as possible.

**This set of questions asks about weight control practices.**

1. Do you have access to a scale to weigh yourself?

No  Yes →



Skip to question 2

1.1 How often do you weigh yourself? (Mark one answer only.)

Never  
 About once a year or less  
 Every couple months  
 Every month  
 Every week  
 Every day  
 More than once per day

2. How satisfied are you with your current weight?

- Extremely dissatisfied
- Dissatisfied
- Neither dissatisfied nor satisfied
- Satisfied
- Extremely satisfied

3. Based on your current weight, would you like to: (Mark one answer only.)

- Lose weight → 3.1 How many pounds would you like to lose?    lbs
- Maintain my current weight
- Gain weight → 3.2 How many pounds would you like to gain?    lbs

4. What is your dream weight<sup>1</sup> as of today, a weight that you would choose if you could weigh whatever you wanted?

lbs

5. Looking back on how you have progressed since you underwent your bariatric surgery, how satisfied are you with the results of the surgery?

- Very satisfied
- Satisfied
- Somewhat satisfied
- Neither satisfied nor dissatisfied
- Somewhat dissatisfied
- Dissatisfied
- Very dissatisfied

5.1 Why did you answer that way? Mark "No" or "Yes" to each.

No	Yes	
<input type="checkbox"/>	<input type="checkbox"/>	a. I have seen little or no benefit to my health
<input type="checkbox"/>	<input type="checkbox"/>	b. I am disappointed in the amount of weight I lost
<input type="checkbox"/>	<input type="checkbox"/>	c. I am disappointed in my appearance
<input type="checkbox"/>	<input type="checkbox"/>	d. I can no longer enjoy food
<input type="checkbox"/>	<input type="checkbox"/>	e. I can no longer eat with family or friends
<input type="checkbox"/>	<input type="checkbox"/>	f. I have had complications from the surgery
<input type="checkbox"/>	<input type="checkbox"/>	g. Other, specify: <input type="text"/>

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### Teen-LABS (BF) Behavior Follow-up

**Directions:** The following questions<sup>2</sup> ask about your weight control practices. Please indicate whether you **ever** did any of the activities listed below **in order to control your weight** in the **past 6 months**.

- If you did an activity in order to control your weight in the **past 6 months**, mark "Yes" and follow the arrow to complete the next column indicating **how many weeks** you did the activity in the **past 6 months**. Please note that there are approximately 26 weeks in 6 months.
- If you did **not** do an activity in the **past 6 months** in order to control your weight, mark "No" and go to the next item.

#### For weight control, in the **past 6 months** have you...

How many weeks  
in the past 6 months?

1. counted fat grams?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	→	<input type="text"/>
2. decreased fat intake?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	→	<input type="text"/>
3. reduced the number of calories you eat?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	→	<input type="text"/>
4. used a very low calorie diet?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	→	<input type="text"/>
5. cut out between-meal-snacking?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	→	<input type="text"/>
6. eaten fewer high carbohydrate foods like bread or potatoes?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	→	<input type="text"/>
7. eaten special low calorie diet foods?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	→	<input type="text"/>
8. eaten or drank meal replacements?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	→	<input type="text"/>
9. increased fruits and vegetables?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	→	<input type="text"/>
10. cut out non-diet soda pop or other sugar-sweetened beverages?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	→	<input type="text"/>
11. chewed and spit out food?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	→	<input type="text"/>
12. drank fewer alcoholic beverages for weight control?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	→	<input type="text"/>
13. smoked cigarettes for weight control?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	→	<input type="text"/>
14. induced vomiting for weight control?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	→	<input type="text"/>
15. recorded what you eat daily?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	→	<input type="text"/>
16. kept a graph of your weight?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	→	<input type="text"/>
17. increased your exercise level?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	→	<input type="text"/>
18. used home exercise equipment?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	→	<input type="text"/>
19. recorded your exercise daily?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	→	<input type="text"/>
20. participated in group exercise classes?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	→	<input type="text"/>
21. participated in a support/self help group? (e.g., <i>Weight Watchers, TOPS</i> )	<input type="checkbox"/> No	<input type="checkbox"/> Yes	→	<input type="text"/>
22. accessed a discussion group, bulletin board, or chat room on the internet?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	→	<input type="text"/>
23. used hypnosis for weight control?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	→	<input type="text"/>
24. used laxatives for weight control?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	→	<input type="text"/>
25. used any prescription medication? (e.g., <i>Wellbutrin, Xenical, Medridia, Trexan, Ionamin, Adipex, Phentermine plus Fenfluramine, Topamax, Pondimin, Redux, Dexedrine</i> )	<input type="checkbox"/> No	<input type="checkbox"/> Yes	→	<input type="text"/>
26. used any dietary supplement or non-prescription medication?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	→	<input type="text"/>

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### Teen-LABS (BF) Behavior Follow-up

**Directions:** The following questions ask about whether you have seen any of the professionals listed below **in order to control your weight** in the **past 6 months**.

- In the **past 6 months**, if you saw one of the professionals listed below in order to control your weight, mark "Yes" and follow the arrow to complete the next column indicating **how many times** you saw the professional.
- If you did **not** see the professional in the past 6 months in order to control your weight, mark "No" and go to the next item.

For weight control, in the <u>past 6 months</u> have you...	How many times in the <u>past 6 months</u> ?			
	1 to 5 times	6 to 10 times	11 to 20 times	more than 20 times
1. seen a counselor/mental health professional? <input type="checkbox"/> No <input type="checkbox"/> Yes    →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. seen a nutritionist/dietitian? <input type="checkbox"/> No <input type="checkbox"/> Yes    →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. seen a personal trainer or exercise specialist? <input type="checkbox"/> No <input type="checkbox"/> Yes    →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*The next set of questions asks about your eating habits during a usual or normal week.*

1. Thinking about your **usual or normal week**...

- a. How many days out of the **7-day week** do you eat breakfast?       days/week
- b. How many days out of the **7-day week** do you eat lunch/brunch?       days/week
- c. How many days out of the **7-day week** do you eat dinner?       days/week
- d. Counting all meals and any snacks you may have, **how many times a day** do you eat? (*Mark box if more than 10 times/day.*)        times/day or  more than 10 times a day

2. How many days a week do you **eat out** at...

Breakfast

Brunch/Lunch

Dinner

- a. Fast food restaurants:       days/week       days/week       days/week
- b. Other types of restaurants:       days/week       days/week       days/week

*The next questions<sup>3</sup> ask about your eating habits over the past 6 months.*

1. During the **past 6 months**, have you had times when you eat continuously during the day or parts of the day without planning what and how much you would eat?

No     Yes    →

1.1 Did you experience a loss of control, that is, you felt like you could not control your eating?

No     Yes

↓  
*Skip to  
question 2  
on page 4*

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### Teen-LABS (BF) Behavior Follow-up

2. During the **past 6 months**, did you ever eat within any two-hour period what most people would regard as an unusually large amount of food?

No  Yes →

↓  
Skip to  
question 3

2.1 During the **past 6 months**, how often, on average, did you have times when you ate this way -- that is, large amounts of food **plus** the feeling that your eating was out of control? (*There may have been some weeks when it was not present - just average those in.*)

Less than one day a week  Two or three days a week  Nearly every day

One day a week  Four or five days a week

2.2 Did you **usually** have any of the following experiences during these occasions?

a. Eating much more rapidly than usual.  No  Yes

b. Eating until you felt uncomfortably full.  No  Yes

c. Eating large amounts of food when you didn't feel physically hungry.  No  Yes

d. Eating alone because you were embarrassed by how much you were eating.  No  Yes

e. Feeling disgusted with yourself, depressed, or feeling very guilty after overeating.  No  Yes

2.3 During the **past 6 months**, when you overate, how upset were you from overeating (eating more than you think is best for you)?

Not at all  Slightly  Moderately  Greatly  Extremely

3. In general, during the **past 6 months**, when you felt like your eating was out of control, how upset were you by the feeling that you couldn't stop eating or control what or how much you were eating?

Not at all  Slightly  Moderately  Greatly  Extremely

4. During the **past 6 months**, how important has your weight or shape been in how you feel about or evaluate yourself as a person -- as compared to other aspects of your life, such as how you do at school, work, as a parent, or how you get along with other people?

Weight and shape were **not very important**.

Weight and shape **played a part** in how I felt about myself.

Weight and shape **were among the main things** that affected how I felt about myself.

Weight and shape **were the most important things** that affected how I felt about myself.

*This next set of questions asks about activities related to binge eating (consuming large amounts of food in a short period of time) over the **past 3 months**.*

1. In the **past 3 months**, have you had any episodes of binge eating?

No  Yes

↓  
Skip to  
question 8  
on page 6

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### Teen-LABS (BF) Behavior Follow-up

2. During the **past 3 months**, did you ever make yourself vomit to avoid gaining weight after binge eating?

No  Yes →

↓  
*Skip to  
question 3*

2.1 How often, **on average**, was that?

- Less than once a week
- Once a week
- Two or three times a week
- Four or five times a week
- More than five times a week

3. During the **past 3 months**, did you ever take more than twice the recommended dose of laxatives in order to avoid gaining weight after binge eating?

No  Yes →

↓  
*Skip to  
question 4*

3.1 How often, **on average**, was that?

- Less than once a week
- Once a week
- Two or three times a week
- Four or five times a week
- More than five times a week

4. During the **past 3 months**, did you ever take more than twice the recommended dose of diuretics (water pills) in order to avoid gaining weight after binge eating?

No  Yes →

↓  
*Skip to  
question 5*

4.1 How often, **on average**, was that?

- Less than once a week
- Once a week
- Two or three times a week
- Four or five times a week
- More than five times a week

5. During the **past 3 months**, did you ever fast (not eating anything at all for at least 24 hours) in order to avoid gaining weight after binge eating?

No  Yes →

↓  
*Skip to  
question 6*

5.1 How often, **on average**, was that?

- Less than once a week
- Once a week
- Two or three times a week
- Four or five times a week
- More than five times a week

6. During the **past 3 months**, did you ever exercise for more than an hour **specifically** in order to avoid gaining weight after binge eating?

No  Yes →

↓  
*Skip to  
question 7  
on page 6*

6.1 How often, **on average**, was that?

- Less than once a week
- Once a week
- Two or three times a week
- Four or five times a week
- More than five times a week

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### Teen-LABS (BF) Behavior Follow-up

7. During the **past 3 months**, did you ever take twice the recommended dose of a diet pill in order to avoid gaining weight after binge eating?

No     Yes    →

↓  
*Skip to  
question 8*

7.1 How often, **on average**, was that?

Less than once a week

Once a week

Two or three times a week

Four or five times a week

More than five times a week

8. During the **past 3 months**, have you withheld your use of insulin to try to control your weight?

I do not use insulin     No     Yes

*This next set of questions<sup>4</sup> asks about how you have felt and how often you did various activities in the **past 3 months**.*

1. During the **past 3 months**, on average, how many hours per day did you spend watching TV, using a computer, and/or playing video games?

None     1 hour or less     1 to 2 hours     2 to 4 hours     More than 4 hours

2. During the **past 3 months**, how much of your daily food intake did you consume after suppertime?

None     Up to a quarter     About half     More than half     Almost all

3. During the **past 3 months**, how hungry were you on a usual morning?

Not at all     A little     Somewhat     Moderately     Very

4. During the **past 3 months**, how often did you have trouble getting to sleep?

Never     Sometimes     About half the time     Usually     Always

5. Other than to use the bathroom, during the **past 3 months**, how often did you get up at least once in the middle of the night?

Never     Less than once a week     About once a week     More than once a week     Every night

↓  
*Skip to  
question 7  
on page 7*

6. During the **past 3 months**, when you got up in the middle of the night, how often did you snack?

Never    → *Skip to question 7 on page 7*

Sometimes \_\_\_\_\_

About half the time \_\_\_\_\_

Usually \_\_\_\_\_

Always \_\_\_\_\_

6.1 When you snacked in the middle of the night, how aware were you of your eating?

Not at all     A little     Somewhat     Very much     Completely

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### Teen-LABS (BF) Behavior Follow-up

7. During the **past 3 months**, were you in an occupation involving night or evening shifts or other unusual time requirements that interfere with meals?

- No     Yes

8. During the **past 3 months**, how often did you keep eating a meal even though you were not hungry any more?

- Rarely or never     Occasionally (once per week)     Frequently (more than once per week)     Nearly every day

9. During the **past 3 months**, how often did you keep eating a meal even though you felt full?

- Rarely or never     Occasionally (once per week)     Frequently (more than once per week)     Nearly every day

10. Over the **past 3 months**, have you had problems with the small opening in your stomach becoming plugged (food getting stuck)?

- Never → *Skip to question 11*

- Monthly or less \_\_\_\_\_
- More than monthly but less than weekly \_\_\_\_\_
- About weekly \_\_\_\_\_
- Several times/week \_\_\_\_\_
- Daily \_\_\_\_\_
- Several times/day \_\_\_\_\_



10.1 When food gets stuck, what do you usually do?

Food comes back spontaneously

Wait until gone

Induce vomiting (water, finger, coughing, bending over toilet)

Go to the hospital or seek medical treatment

11. Over the **past 3 months**, how often have you chewed food (put food into your mouth) and spit it out without swallowing it?

- Never
- Monthly or less
- More than monthly but less than weekly
- About weekly
- Several times/week
- Daily
- Several times/day

12. Over the **past 3 months**, how often have you self-induced vomiting because of concerns about weight gain?

- Never
- Monthly or less
- More than monthly but less than weekly
- About weekly
- Several times/week
- Daily
- Several times/day

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### Teen-LABS (BF) Behavior Follow-up

13. Over the **past 3 months**, how often have you vomited involuntarily?

- Never
- Monthly or less
- More than monthly but less than weekly
- About weekly
- Several times/week
- Daily
- Several times/day

14. Over the **past 3 months**, how often have you self-induced vomiting because you felt too full?

- Never
- Monthly or less
- More than monthly but less than weekly
- About weekly
- Several times/week
- Daily
- Several times/day

15. How hungry do you usually feel before a meal now compared to before your surgery?

- Much less
- Less
- Somewhat less
- About the same
- Somewhat more
- More
- Much more

16. How much do you enjoy eating now compared to before your surgery?

- Much less
- Less
- Somewhat less
- About the same
- Somewhat more
- More
- Much more

17. How important is eating to you now compared to before your surgery?

- Much less
- Less
- Somewhat less
- About the same
- Somewhat more
- More
- Much more

***The next set of questions asks about eating behaviors. During the past 3 months...***

18. Did you feel "full" after eating only a small amount of food?

- Never
- Rarely
- Sometimes
- Often
- Always

19. Were you able to eat as much as you ate prior to surgery?

- Never
- Rarely
- Sometimes
- Often
- Always

20. Did you have difficulty eating certain types of food, such as meat, that you did not have difficulty with before undergoing bariatric surgery?

- Never
- Rarely
- Sometimes
- Often
- Always

21. Did you have to eat small meals throughout the day?

- Never
- Rarely
- Sometimes
- Often
- Always

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## Teen-LABS (BF) Behavior Follow-up

*The next set of questions<sup>5</sup> asks about alcohol use in the past 12 months.*

1. How often do you have a drink containing alcohol?

- Never → *Skip to next page*  
 Monthly or less  
 Two to four times a month  
 Two to three times per week  
 Four or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

- 1 or 2 drinks    3 or 4 drinks    5 or 6 drinks    7 to 9 drinks    10 or more drinks

3. How often do you have six or more drinks on one occasion?

- Never    Less than monthly    Monthly    Weekly (2 to 3 times/week)    Daily or almost daily (4 or more times a week)

4. How often, during the past 12 months, have you found that you were not able to stop drinking once you had started?

- Never    Less than monthly    Monthly    Weekly (2 to 3 times/week)    Daily or almost daily (4 or more times a week)

5. How often, during the past 12 months, have you failed to do what was normally expected from you because of drinking?

- Never    Less than monthly    Monthly    Weekly (2 to 3 times/week)    Daily or almost daily (4 or more times a week)

6. How often, during the past 12 months, have you needed a first drink in the morning to get yourself going after a heavy drinking session?

- Never    Less than monthly    Monthly    Weekly (2 to 3 times/week)    Daily or almost daily (4 or more times a week)

7. How often, during the past 12 months, have you had a feeling of guilt or remorse after drinking?

- Never    Less than monthly    Monthly    Weekly (2 to 3 times/week)    Daily or almost daily (4 or more times/week)

8. How often, during the past 12 months, have you been unable to remember what happened the night before because you had been drinking?

- Never    Less than monthly    Monthly    Weekly (2 to 3 times/week)    Daily or almost daily (4 or more times a week)

9. Have you or someone else been injured as a result of your drinking?

- No    Yes, but not in the past 12 months    Yes, during the last year

10. Has a relative or friend, or doctor or other health worker been concerned about your drinking and suggested you cut down?

- No    Yes, but not in the past 12 months    Yes, during the last year

11. Does the effect of alcohol on you differ from before surgery?

- No    Yes

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### Teen-LABS (BF) Behavior Follow-up

The next set of questions asks about tobacco use in the last 12 months.

1. Do you currently smoke cigarettes?

No  Yes →

1.1 On average, how many packs per day do you currently smoke?  packs/day

Note: Make sure you report how many PACKS per day you smoke.

20 cigarettes = 1 pack; 10 cigarettes = 1/2 pack = 0.5 pack; 5 cigarettes = 1/4 pack = 0.25 pack

2. Do you currently use other forms of tobacco, such as cigars, cigarillos, chewing tobacco, snuff, dip, etc.?

No  Yes →

2.1 On average, how often do you currently use other forms of tobacco?

Less than monthly  Monthly  2 to 3 times/week  4 to 6 times/week  Daily

The next set of questions asks about substance use in the past 12 months.

**Directions:** Indicate your use of any of the substances listed below. *Note: All of your responses will remain confidential.*

If you did not use a particular substance, mark "No" and go to the next item.

1. In the past 12 months, other than as prescribed by a physician, have you used any of the following:

1.1 Opiates (such as codeine, morphine, heroin, etc.)?	<input type="checkbox"/> No <input type="checkbox"/> Yes
1.2 Amphetamines (such as white crosses, speed, "meth")?	<input type="checkbox"/> No <input type="checkbox"/> Yes
1.3 Hallucinogens (such as LSD, mescaline)?	<input type="checkbox"/> No <input type="checkbox"/> Yes
1.4 Inhalants (such as sniffing glue)?	<input type="checkbox"/> No <input type="checkbox"/> Yes
1.5 Marijuana/hashish/pot?	<input type="checkbox"/> No <input type="checkbox"/> Yes
1.6 Cocaine/crack?	<input type="checkbox"/> No <input type="checkbox"/> Yes
1.7 PCP/Angel dust?	<input type="checkbox"/> No <input type="checkbox"/> Yes

Acknowledgement of the following sources for questions contained on this form:

1. Based in part on: Foster GD, Wadden TA, Vogt RA, Brewer G. What is a reasonable weight loss? Patients' expectations and evaluations of obesity treatment outcomes. J Consult Clin Psychol. 1997;65:79-85.

2. Look AHEAD (Action For Health in Diabetes) Study and based in part on the following sources:

Jeffery RW, French SA: Preventing weight gain in adults: The Pound of Prevention Study. Am J Public Health 1999;89:747-51.

French SA, Jeffery RW, Murray D: Is dieting good for you? Prevalence, duration and associated weight and behaviour changes for specific weight loss strategies over four years in US adults. Int J Obes 1999;23:320-27.

3. QEWP-R© Spitzer RL, Yanovski SZ, Marcus MD. (HaPI Record). 1994; Pittsburgh PA: Behavioral Measurement Database Services (Producer). McLean, VA: BRS Search Service (Vendor).

4. Nighttime Eating Phone Screen, Dr. James Mitchell, Neuropsychiatric Research Institute, Fargo, ND.

5. Saunders JB, Aasland OG, Babor TF et al. Development of the alcohol use disorders identification test (AUDIT): WHO collaborative project on early detection of persons with harmful alcohol consumption – II. Addiction 1993, 88:791-803.

	Site ID: <input type="text"/>	Subject ID: <input type="text"/>	Reviewed by (certification no.): <input type="text"/>	
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**Teen-LABS (SF36) SF-36® Health Survey**

**Form completion date:**  /  / 20 (mm/dd/yyyy)

Please PRINT NEATLY and complete this form in blue or black INK. Mark response boxes like this:

**Directions:** The next set of questions asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. For each of the following question, please mark the one box that best describes your answers.

1. In general, would you say your health is: (mark only one)

Excellent    Very good    Good    Fair    Poor

2. **Compared to one year ago**, how would you rate your health in general **now**? (mark only one)

Much better now than one year ago

Somewhat better now than one year ago

About the same as one year ago

Somewhat worse now than one year ago

Much worse now than one year ago

**Directions:** The following items are about activities you might do during a typical day. **Does your health now limit you** in these activities? If so, how much? (Mark only one response for each question.)

Activities	Yes, limited a lot	Yes, limited a little	No, not limited at all
3. <b>Vigorous activities</b> , such as running, lifting heavy objects, participating in strenuous sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. <b>Moderate activities</b> , such as moving a table, pushing a vacuum cleaner, bowling, or playing golf.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Lifting or carrying groceries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Climbing <b>several</b> flights of stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Climbing <b>one</b> flight of stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Bending, kneeling, or stooping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Walking <b>more than a mile</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Walking <b>several blocks</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Walking <b>one block</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Bathing or dressing yourself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Site ID: <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/>	Subject ID: <input style="width: 30px; height: 20px;" type="text"/>	<b>For coordinator use only.</b>
Visit: <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/>		

**Teen-LABS (SF36) SF-36® Health Survey**

**Directions:** During the **past 4 weeks** have you had any of the following problems with your work or other regular daily activities as a result of your **physical health**. (Mark only one response for each question.)

Activities	No	Yes
13. Cut down on the <b>amount of time</b> you spent on work or other activities	<input type="checkbox"/>	<input type="checkbox"/>
14. <b>Accomplished less</b> than you would like	<input type="checkbox"/>	<input type="checkbox"/>
15. Were limited in the kind of work or other activities	<input type="checkbox"/>	<input type="checkbox"/>
16. Had difficulty performing the work or other activities (for example, it took extra effort)	<input type="checkbox"/>	<input type="checkbox"/>

**Directions:** During the **past 4 weeks** have you had any of the following problems with your work or other regular daily activities as a result of any **emotional problems** (such as feeling depressed or anxious)? (Mark only one response for each question.)

Activities	No	Yes
17. Cut down on the <b>amount of time</b> you spent on work or other activities	<input type="checkbox"/>	<input type="checkbox"/>
18. <b>Accomplished less</b> than you would like	<input type="checkbox"/>	<input type="checkbox"/>
19. Did work or other activities less carefully than usual	<input type="checkbox"/>	<input type="checkbox"/>

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

- Not at all    Slightly    Moderately    Quite a bit    Extremely

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

- None    Very mild    Mild    Moderate    Severe    Very severe

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

- Not at all    Slightly    Moderately    Quite a bit    Extremely

	Site ID: <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	Subject ID: <input style="width: 20px; height: 20px;" type="text"/>	
	Visit: <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	<b>For coordinator use only.</b>	

**Teen-LABS (SF36) SF-36® Health Survey**

**Directions:** These questions are about how you feel and how things have been with you during the **past 4 weeks**. For each question, please give the one answer that come closest to the way you have been feeling. *(Mark one response for each question.)*

How much of the time during the <b>past 4 weeks</b> ...	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
23. Did you feel full of pep?	<input type="checkbox"/>					
24. Have you been a very nervous person?	<input type="checkbox"/>					
25. Have you felt so down in the dumps that nothing could cheer you up?	<input type="checkbox"/>					
26. Have you felt calm and peaceful?	<input type="checkbox"/>					
27. Did you have a lot of energy?	<input type="checkbox"/>					
28. Have you felt downhearted and blue?	<input type="checkbox"/>					
29. Did you feel worn out?	<input type="checkbox"/>					
30. Have you been a happy person?	<input type="checkbox"/>					
31. Did you feel tired?	<input type="checkbox"/>					

32. During the **past 4 weeks**, how much of the time has **your physical health or emotional problems** interfered with your social activities (like visiting with friends, relatives, etc.)? *(Mark one response.)*

- All of the time
- Most of the time
- Some of the time
- A little of the time
- None of the time

**Directions:** How "True" or "False" is **each** of the following statements for you? *(Mark one response for each question.)*

Statements	Definitely true	Mostly true	Don't know	Mostly false	Definitely false
33. I seem to get sick a little easier than other people.	<input type="checkbox"/>				
34. I am as healthy as anybody I know.	<input type="checkbox"/>				
35. I expect my health to get worse.	<input type="checkbox"/>				
36. My health is excellent.	<input type="checkbox"/>				

	Site ID: <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	Subject ID: <input style="width: 20px; height: 20px;" type="text"/>	Reviewed by (certification no.): <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	
	Visit: <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	<b>For coordinator use only.</b>	Review date: <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/>	

## Teen-LABS (BDI-II)

**Form completion date:**  /  / 20 (mm/dd/yyyy)

Please PRINT NEATLY and complete this form in blue or black INK. Mark response boxes like this:

**Instructions:** This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the **one statement** in each group that best describes the way you have been feeling during the **past two weeks, including today**. Mark the box beside the statement you have picked. If several statements in the group seem to apply equally well, mark the one with the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

### 1. Sadness

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

### 2. Pessimism

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

### 3. Past Failure

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

### 4. Loss of Pleasure

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

### 5. Guilty Feelings

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

### 6. Punishment Feelings

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

### 7. Self-Dislike

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

### 8. Self-Criticalness

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

### 9. Suicidal Thoughts or Wishes

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

### 10. Crying

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

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### Teen-LABS (BDI-II)

#### 11. Agitation

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

#### 12. Loss of Interest

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

#### 13. Indecisiveness

- 0 I make decisions about as well as ever.
- 1 I find it more difficult to make decisions than usual.
- 2 I have much greater difficulty in making decisions than I used to.
- 3 I have trouble making any decisions.

#### 14. Worthlessness

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

#### 15. Loss of Energy

- 0 I have as much energy as ever.
- 1 I have less energy than I used to have.
- 2 I don't have enough energy to do very much.
- 3 I don't have enough energy to do anything.

#### 16. Changes in Sleeping Pattern

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

#### 17. Irritability

- 0 I am no more irritable than usual.
- 1 I am more irritable than usual.
- 2 I am much more irritable than usual.
- 3 I am irritable all the time.

#### 18. Changes in Appetite

- 0 I have not experienced any change in my appetite.
- 1a My appetite is somewhat less than usual.
- 1b My appetite is somewhat greater than usual.
- 2a My appetite is much less than before.
- 2b My appetite is much greater than usual.
- 3a I have no appetite at all.
- 3b I crave food all the time.

#### 19. Concentration Difficulty

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

#### 20. Tiredness or Fatigue

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

#### 21. Loss of Interest in Sex

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

<b>Site ID:</b> <input type="text"/>	<b>Subject ID:</b> <input type="text"/>	<b>Reviewed by (certification no.):</b> <input type="text"/>	
<b>Visit:</b> <input type="text"/>	<b>For coordinator use only.</b>	<b>Review date:</b> <input type="text"/> / <input type="text"/> / <input type="text"/>	

### Teen-LABS (PETSb)

**Form completion date:**  /  /  (mm/dd/yyyy)

Please PRINT NEATLY and complete this form in blue or black INK. Mark response boxes like this:

1. Have you **ever been** admitted to a hospital (including partial hospitalization or day hospital treatment) for treatment of psychiatric or emotional problems?

No       Yes

↓                      ↓

*Skip to question 2*

1.1 Total number of hospital admissions (including partial and day hospital) for treatment of psychiatric or emotional problems in your lifetime:  (if none, enter "0")

1.2 Number of inpatient (overnight) hospital admissions for treatment of psychiatric or emotional problems in the **past 12 months**:  (if none, enter "0")

1.3 Number of partial hospital/day hospital admissions for treatment of psychiatric or emotional problems in the **past 12 months**:  (if none, enter "0")

1.4 What was the **most recent** psychiatric or emotional problem(s) you were treated for in a hospital? (Mark "No" or "Yes" for each.)

<u>No</u>	<u>Yes</u>		<u>No</u>	<u>Yes</u>	
<input type="checkbox"/>	<input type="checkbox"/>	a. Depression	<input type="checkbox"/>	<input type="checkbox"/>	g. Bipolar disorder
<input type="checkbox"/>	<input type="checkbox"/>	b. Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	h. Self injury
<input type="checkbox"/>	<input type="checkbox"/>	c. Alcohol/drug abuse	<input type="checkbox"/>	<input type="checkbox"/>	i. Suicidal
<input type="checkbox"/>	<input type="checkbox"/>	d. Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>	j. Marital therapy
<input type="checkbox"/>	<input type="checkbox"/>	e. Attention deficit disorder	<input type="checkbox"/>	<input type="checkbox"/>	k. Family therapy
<input type="checkbox"/>	<input type="checkbox"/>	f. Post traumatic stress disorder	<input type="checkbox"/>	<input type="checkbox"/>	l. Other, specify: <input style="width: 150px;" type="text"/>

1.5 Have you **ever** been treated for any other psychiatric or emotional problems in a hospital?

No       Yes

↓

1.5.1 What other psychiatric or emotional problem(s) were you treated for in the **past 12 months**? (Mark "No" or "Yes" for each.)

<u>No</u>	<u>Yes</u>		<u>No</u>	<u>Yes</u>	
<input type="checkbox"/>	<input type="checkbox"/>	a. Depression	<input type="checkbox"/>	<input type="checkbox"/>	g. Bipolar disorder
<input type="checkbox"/>	<input type="checkbox"/>	b. Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	h. Self injury
<input type="checkbox"/>	<input type="checkbox"/>	c. Alcohol/drug abuse	<input type="checkbox"/>	<input type="checkbox"/>	i. Suicidal
<input type="checkbox"/>	<input type="checkbox"/>	d. Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>	j. Marital therapy
<input type="checkbox"/>	<input type="checkbox"/>	e. Attention deficit disorder	<input type="checkbox"/>	<input type="checkbox"/>	k. Family therapy
<input type="checkbox"/>	<input type="checkbox"/>	f. Post traumatic stress disorder	<input type="checkbox"/>	<input type="checkbox"/>	l. Other, specify: <input style="width: 150px;" type="text"/>

Site ID: Subject ID: 

For coordinator use only.

## Teen-LABS (PETSb)

2. Other than within a hospital, in the **past 12 months**, have you been treated by anyone such as a counselor or mental health professional for psychiatric or emotional problems **outside** of your bariatric surgery team?

No     Yes



Skip to  
question 3

2.1 What was the **most recent** psychiatric or emotional problem(s) you were seen for?  
(Mark "No" or "Yes" for each.)

No    Yes

a. Depression

b. Anxiety

c. Alcohol/drug abuse

d. Eating disorder

e. Attention deficit disorder

f. Post traumatic stress disorder

No    Yes

g. Bipolar disorder

h. Self injury

i. Suicidal

j. Marital therapy

k. Family therapy

l. Other, specify:

2.2 Were you treated for any other psychiatric or emotional problems in the **past 12 months**?

No     Yes



2.2.1 What other psychiatric or emotional problem(s) were you treated for in the **past 12 months**?  
(Mark "No" or "Yes" for each.)

No    Yes

a. Depression

b. Anxiety

c. Alcohol/drug abuse

d. Eating disorder

e. Attention deficit disorder

f. Post traumatic stress disorder

No    Yes

g. Bipolar disorder

h. Self injury

i. Suicidal

j. Marital therapy

k. Family therapy

l. Other, specify:

2.3 Are you **currently** seeing anybody for psychiatric or emotional problems?     No     Yes

2.4 How often have you, during the **past 6 months**, seen a mental health counselor/professional for psychiatric or emotional problems?

Never     1 to 5 times     6 to 10 times     11 to 20 times     more than 20 times

3. Have you **ever** taken any medications for psychiatric or emotional problems?

No     Yes



	Have you <b>ever</b> taken... <i>if ever</i>			Are you <b>currently</b> taking...	
3.1 Antidepressants (e.g., Prozac, Zoloft, Paxil)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	→	<input type="checkbox"/> No	<input type="checkbox"/> Yes
3.2 Major tranquilizers (e.g., Risperdal, Zyprexa)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	→	<input type="checkbox"/> No	<input type="checkbox"/> Yes
3.3 Minor tranquilizers (e.g., Ativan, Xanax)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	→	<input type="checkbox"/> No	<input type="checkbox"/> Yes
3.4 Mood stabilizers (e.g., Lithobid, Tegretol, Topamax)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	→	<input type="checkbox"/> No	<input type="checkbox"/> Yes
3.5 Stimulants (e.g., Ritalin, methylin)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	→	<input type="checkbox"/> No	<input type="checkbox"/> Yes
3.6 Other medication, specify:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	→	<input type="checkbox"/> No	<input type="checkbox"/> Yes

Site ID:

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**Teen-LABS (PETSb)**

4. Did you have a mental health evaluation (includes evaluation by social worker) prior to being accepted for bariatric surgery?

No

Yes



*Skip to  
question 5*

4.1 Were you told to seek counseling or other mental health care prior to surgery?

No

Yes



*Skip to  
question 5*

4.1.1 Did you do so?  No  Yes

4.1.2 How many sessions did you attend?  (If none, enter '0')

5. Did you have nutritional counseling by a dietitian prior to being enrolled in the bariatric program?

No

Yes



5.1 How many sessions?  (If none, enter '0')

**Teen-LABS (PETF)**

**Form completion date:**   /   /     (mm/dd/yyyy)

Please PRINT NEATLY and complete this form in blue or black INK. Mark response boxes like this:

1. In the **past 12 months**, have you been admitted to a hospital (including partial hospitalization or day hospital treatment) for treatment of psychiatric or emotional problems?

No  Yes

↓ ↓

*Skip to question 2*

1.1 Total number of hospital admissions (including partial and day hospital) for treatment of psychiatric or emotional problems in the **past 12 months**:   (if none, enter "0")

1.2 Number of inpatient (overnight) hospital admissions for treatment of psychiatric or emotional problems in the **past 12 months**:   (if none, enter "0")

1.3 Number of partial hospital/day hospital admissions for treatment of psychiatric or emotional problems in the **past 12 months**:   (if none, enter "0")

1.4 What was the **most recent** psychiatric or emotional problem(s) you were treated for in a hospital? (Mark "No" or "Yes" for each.)

<u>No</u>	<u>Yes</u>		<u>No</u>	<u>Yes</u>	
<input type="checkbox"/>	<input type="checkbox"/>	a. Depression	<input type="checkbox"/>	<input type="checkbox"/>	g. Bipolar disorder
<input type="checkbox"/>	<input type="checkbox"/>	b. Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	h. Self injury
<input type="checkbox"/>	<input type="checkbox"/>	c. Alcohol/drug abuse	<input type="checkbox"/>	<input type="checkbox"/>	i. Suicidal
<input type="checkbox"/>	<input type="checkbox"/>	d. Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>	j. Marital therapy
<input type="checkbox"/>	<input type="checkbox"/>	e. Attention deficit disorder	<input type="checkbox"/>	<input type="checkbox"/>	k. Family therapy
<input type="checkbox"/>	<input type="checkbox"/>	f. Post traumatic stress disorder	<input type="checkbox"/>	<input type="checkbox"/>	l. Other, specify: <input type="text"/>

1.5 Were you treated for any other psychiatric or emotional problems in a hospital?

No  Yes

↓

1.5.1 What other psychiatric or emotional problem(s) were you treated for in the **past 12 months**? (Mark "No" or "Yes" for each.)

<u>No</u>	<u>Yes</u>		<u>No</u>	<u>Yes</u>	
<input type="checkbox"/>	<input type="checkbox"/>	a. Depression	<input type="checkbox"/>	<input type="checkbox"/>	g. Bipolar disorder
<input type="checkbox"/>	<input type="checkbox"/>	b. Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	h. Self injury
<input type="checkbox"/>	<input type="checkbox"/>	c. Alcohol/drug abuse	<input type="checkbox"/>	<input type="checkbox"/>	i. Suicidal
<input type="checkbox"/>	<input type="checkbox"/>	d. Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>	j. Marital therapy
<input type="checkbox"/>	<input type="checkbox"/>	e. Attention deficit disorder	<input type="checkbox"/>	<input type="checkbox"/>	k. Family therapy
<input type="checkbox"/>	<input type="checkbox"/>	f. Post traumatic stress disorder	<input type="checkbox"/>	<input type="checkbox"/>	l. Other, specify: <input type="text"/>

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## Teen-LABS (PETF)

2. Other than within a hospital, in the **past 12 months**, have you been treated by anyone such as a counselor or mental health professional for psychiatric or emotional problems **outside** of your bariatric surgery team?

No     Yes



Skip to  
question 3

2.1 What was the **most recent** psychiatric or emotional problem(s) you were seen for?

(Mark "No" or "Yes" for each.)

No    Yes

a. Depression

NoYes

g. Bipolar disorder

b. Anxiety

h. Self injury

c. Alcohol/drug abuse

i. Suicidal

d. Eating disorder

j. Marital therapy

e. Attention deficit disorder

k. Family therapy

f. Post traumatic stress disorder

l. Other, specify:

2.2 Were you treated for any other psychiatric or emotional problems in the **past 12 months**?

No     Yes



2.2.1 What other psychiatric or emotional problem(s) were you treated for in the **past 12 months**?

(Mark "No" or "Yes" for each.)

No    Yes

a. Depression

NoYes

g. Bipolar disorder

b. Anxiety

h. Self injury

c. Alcohol/drug abuse

i. Suicidal

d. Eating disorder

j. Marital therapy

e. Attention deficit disorder

k. Family therapy

f. Post traumatic stress disorder

l. Other, specify:

2.3 Are you **currently** seeing anybody for psychiatric or emotional problems?     No     Yes

2.4 How often have you, during the **past 6 months**, seen a mental health counselor/professional for psychiatric or emotional problems?

Never     1 to 5 times     6 to 10 times     11 to 20 times     more than 20 times

3. In the **past 12 months**, have you taken any medications for psychiatric or emotional problems?

No     Yes



	Have you <b>ever</b> taken... <i>if ever</i>			Are you <b>currently</b> taking...	
3.1 Antidepressants (e.g., Prozac, Zoloft, Paxil)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	→	<input type="checkbox"/> No	<input type="checkbox"/> Yes
3.2 Major tranquilizers (e.g., Risperdal, Zyprexa)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	→	<input type="checkbox"/> No	<input type="checkbox"/> Yes
3.3 Minor tranquilizers (e.g., Ativan, Xanax)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	→	<input type="checkbox"/> No	<input type="checkbox"/> Yes
3.4 Mood stabilizers (e.g., Lithobid, Tegretol, Topamax)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	→	<input type="checkbox"/> No	<input type="checkbox"/> Yes
3.5 Stimulants (e.g., Ritalin, methylin)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	→	<input type="checkbox"/> No	<input type="checkbox"/> Yes
3.6 Other medication, specify:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	→	<input type="checkbox"/> No	<input type="checkbox"/> Yes

<b>Site ID:</b> <input style="width: 30px; height: 20px;" type="text"/>	<b>Subject ID:</b> <input style="width: 60px; height: 20px;" type="text"/>	<b>Reviewed by (certification no.):</b> <input style="width: 40px; height: 20px;" type="text"/>	
<b>Visit:</b> <input style="width: 30px; height: 20px;" type="text"/>	<b>For coordinator use only.</b>	<b>Review date:</b> <input style="width: 30px; height: 20px;" type="text"/> / <input style="width: 30px; height: 20px;" type="text"/> / <input style="width: 30px; height: 20px;" type="text"/>	

**Teen-LABS (IWQOL)**

**Form completion date:**  /  / 20 (mm/dd/yyyy)

Please PRINT NEATLY and complete this form in blue or black INK.

Please answer the following statements by circling the number that best applies to you in the past seven days. Be as open as possible. There are no right or wrong answers.

<u>Physical Comfort</u>	ALWAYS TRUE	USUALLY TRUE	SOMETIMES TRUE	RARELY TRUE	NEVER TRUE
1. Because of my weight I avoid using stairs whenever possible.	1	2	3	4	5
2. Because of my weight it is hard for me to bend over to tie my shoes or to pick something up off the floor.	1	2	3	4	5
3. Because of my weight it is hard for me to move around.	1	2	3	4	5
4. Because of my weight it is hard for me to fit into seats in public places (e.g., movie theaters, desks at school, booths in restaurants).	1	2	3	4	5
5. Because of my weight my knees or ankles hurt.	1	2	3	4	5
6. Because of my weight it is hard for me to cross my legs.	1	2	3	4	5

<u>Body Esteem</u>	ALWAYS TRUE	USUALLY TRUE	SOMETIMES TRUE	RARELY TRUE	NEVER TRUE
7. Because of my weight I am ashamed of my body.	1	2	3	4	5
8. Because of my weight I don't like myself very much.	1	2	3	4	5
9. Because of my weight I try not to look at myself in mirrors or in photographs.	1	2	3	4	5
10. Because of my weight I have a hard time believing compliments that I receive from others.	1	2	3	4	5
11. Because of my weight I am lacking in self-confidence.	1	2	3	4	5
12. Because of my weight I avoid activities that involve wearing shorts or a bathing suit.	1	2	3	4	5
13. Because of my weight it is very difficult for me to buy clothing.	1	2	3	4	5
14. Because of my weight I don't like to change my clothes or undress in front of others.	1	2	3	4	5
15. Because of my weight I am embarrassed to try out for activities at school.	1	2	3	4	5

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Site ID: Subject ID: Visit: 

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**Teen-LABS (IWQOL)**

<b><u>Social Life</u></b>	<b>ALWAYS TRUE</b>	<b>USUALLY TRUE</b>	<b>SOMETIMES TRUE</b>	<b>RARELY TRUE</b>	<b>NEVER TRUE</b>
16. Because of my weight people tease me or make fun of me.	1	2	3	4	5
17. Because of my weight people talk about me behind my back.	1	2	3	4	5
18. Because of my weight people avoid spending time with me.	1	2	3	4	5
19. Because of my weight people stare at me.	1	2	3	4	5
20. Because of my weight I have trouble making or keeping friends.	1	2	3	4	5
21. Because of my weight people don't think I'm very smart.	1	2	3	4	5

<b><u>Family Relations</u></b>	<b>ALWAYS TRUE</b>	<b>USUALLY TRUE</b>	<b>SOMETIMES TRUE</b>	<b>RARELY TRUE</b>	<b>NEVER TRUE</b>
22. Because of my weight family members treat me differently from the way they treat other people.	1	2	3	4	5
23. Because of my weight family members talk about me behind my back.	1	2	3	4	5
24. Because of my weight one or more people in my family reject me.	1	2	3	4	5
25. Because of my weight my parents aren't proud of me.	1	2	3	4	5
26. Because of my weight family members make fun of me.	1	2	3	4	5
27. Because of my weight family members don't want to be seen with me.	1	2	3	4	5

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<b>Site ID:</b> <input type="text"/>	<b>Subject ID:</b> <input type="text"/>	<b>Reviewed by (certification no.):</b> <input type="text"/>	
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### Teen-LABS (GSRS) Gastrointestinal Symptoms Rating Scale

**Form completion date:**  /  /  (mm/dd/yyyy)

Please PRINT NEATLY and complete this form in blue or black INK.

**Directions:** The next set of questions asks about discomfort you may have experienced during the past week. Write the number of your selection in the box provided in front of each question.

<b>No discomfort at all</b>	<b>Minor discomfort</b>	<b>Mild discomfort</b>	<b>Moderate discomfort</b>	<b>Moderately severe discomfort</b>	<b>Severe discomfort</b>	<b>Very severe discomfort</b>
(1)	(2)	(3)	(4)	(5)	(6)	(7)

1. Have you been bothered by **pain or discomfort in you upper abdomen or the pit of your stomach** during the **past week**?
2. Have you been bothered by **heartburn** during the **past week**? (By heartburn we mean an unpleasant stinging or burning sensation in the chest.)
3. Have you been bothered by **acid reflux** during the **past week**? (By acid reflux we mean the sensation of regurgitating small quantities of acid or flow of sour or bitter fluid from the stomach up to the throat.)
4. Have you been bothered by **hunger pains** during the **past week**? (This hollow feeling in the stomach is associated with the need to eat between meals.)
5. Have you been bothered by **nausea** during the **past week**? (By nausea we mean a feeling of wanting to throw up or vomit.)
6. Have you been bothered by **rumbling** in your stomach during the **past week**? (Rumbling refers to vibrations or noise in the stomach.)
7. Has your stomach felt **bloated** during the **past week**? (Feeling bloated refers to swelling often associated with a sensation of gas or air in the stomach.)
8. Have you been bothered by **burping** during the **past week**? (Burping refers to bringing up air or gas from the stomach via the mouth, often associated with a bloated feeling.)
9. Have you been bothered by **passing gas or flatus** during the **past week**? (Passing gas or flatus refers to the need to release air or gas from the bowel, often associated with easing a bloated feeling.)
10. Have you been bothered by **constipation** during the **past week**? (Constipation refers to a reduced ability to empty the bowels.)
11. Have you been bothered by **diarrhea** during the **past week**? (Diarrhea refers to a too frequent emptying of the bowels.)
12. Have you been bothered by **loose stools** during the **past week**? (If your stools (motions) have been alternately hard and loose, this question only refers to the extent you have been bothered by the stools being loose.)
13. Have you been bothered by **hard stools** during the **past week**? (If your stools (motions) have been alternately hard and loose, this question only refers to the extent you have been bothered by the stools being hard.)
14. Have you been bothered by **an urgent need to have a bowel movement** during the **past week**? (This urgent need to go to the toilet is often associated with a feeling that you are not in full control.)
15. When going to the toilet during the **past week**, have you had the **sensation of not completely emptying the bowels**? (This feeling of incomplete emptying means that you still feel the need to pass more stool despite having exerted yourself to do so.)

<b>Site ID:</b> <input type="text"/>	<b>Subject ID:</b> <input type="text"/>	<b>Reviewed by (certification no.):</b> <input type="text"/>	
<b>Visit:</b> <input type="text"/>	<b>For coordinator use only.</b>	<b>Review date:</b> <input type="text"/> / <input type="text"/> / <input type="text"/>	

**Teen-LABS (UIB)**

**Form completion date:**  /  / 20 (mm/dd/yyyy)

Please PRINT NEATLY and complete this form in blue or black INK. Mark response boxes like this: ☒

**Directions:** For the following questions, please consider the **past 3 months**.

1. Many people complain that they leak urine accidentally. In the **past 3 months**, how often have you typically leaked urine, even a small amount? (Please record urine loss for any reason and mark one box only.)

- Never → Skip to question 8
- Less than once per month → Skip to question 8
- Monthly (once or more each month) → Skip to question 8
- Weekly (once or more each week)
- Daily (once or more each day)

2. In the **past 3 months**, how much urine have you typically lost with each episode of urine loss?

- Drops
- Small splashes (1 to 2 teaspoons)
- More

3. In the **past 3 months, in a typical week**, how often have you leaked urine, even a small amount:

- a. with a physical activity like coughing, sneezing, lifting, or exercise?  times per week
- b. with an urge or the feeling that you needed to empty your bladder but you could not get to the toilet fast enough?  times per week
- c. for other reasons (**without** any physical activity and **without** a sense of urgency)?  times per week

4. In the **past 3 months, in a typical week**, have you used supplies (pads or protection) specifically for your urine leakage?

- No    Yes →



Skip to question 5

4.1 How many of each of the supplies listed below have you used **in a typical week specifically for your urine leakage**?

- a. Panty liners or minipads  pads per week
- b. Maxipads such as Kotex or Modess  pads per week
- c. Incontinence pads such as Serenity or Poise  pads per week
- d. Disposable undergarment or protective underwear  undergarments per week

Site ID:

Subject ID:

Visit:

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### Teen-LABS (UIB)

5. In the **past 3 months**, have you had treatments for urine leakage?

No  Yes →

5.1 Please specify treatment(s). *Mark "No" or "Yes" to each.*

No   Yes

   Medication

   Kegel exercises, biofeedback, bladder training (behavioral therapy)

   Changes in fluid intake (decrease fluids, stop caffeine)

   Other *please describe*: \_\_\_\_\_

6. In the **past 3 months**, how much has your urine leakage **affected your day-to-day activities**?

Not at all    Slightly    Moderately    Quite a bit    Extremely

7. In the **past 3 months**, how much has your urine leakage **bothered** you?

Not at all    Slightly    Moderately    Quite a bit    Extremely

8. Have you **ever** had surgery for urine leakage?

No    Yes → When (specify year): \_\_\_\_\_

<b>Site ID:</b> <input type="text"/>	<b>Subject ID:</b> <input type="text"/>	<b>Reviewed by (certification no.):</b> <input type="text"/>	
<b>Visit:</b> <input type="text"/>	<b>For coordinator use only.</b>	<b>Review date:</b> <input type="text"/> / <input type="text"/> / <input type="text"/>	

### Teen-LABS (UIF)

**Form completion date:**  /  / 20 (mm/dd/yyyy)

Please PRINT NEATLY and complete this form in blue or black INK. Mark response boxes like this: ☒

**Directions:** For the following questions, please consider the **past 3 months**.

1. Many people complain that they leak urine accidentally. In the **past 3 months**, how often have you typically leaked urine, even a small amount? (Please record urine loss for any reason and mark one box only.)

- Never → Skip to question 8
- Less than once per month → Skip to question 8
- Monthly (once or more each month) → Skip to question 8
- Weekly (once or more each week)
- Daily (once or more each day)

2. In the **past 3 months**, how much urine have you typically lost with each episode of urine loss?

- Drops
- Small splashes (1 to 2 teaspoons)
- More

3. In the **past 3 months, in a typical week**, how often have you leaked urine, even a small amount:

- a. with a physical activity like coughing, sneezing, lifting, or exercise?  times per week
- b. with an urge or the feeling that you needed to empty your bladder but you could not get to the toilet fast enough?  times per week
- c. for other reasons (**without** any physical activity and **without** a sense of urgency)?  times per week

4. In the **past 3 months, in a typical week**, have you used supplies (pads or protection) specifically for your urine leakage?

- No    Yes →



Skip to question 5

4.1 How many of each of the supplies listed below have you used **in a typical week specifically for your urine leakage?**

- a. Panty liners or minipads  pads per week
- b. Maxipads such as Kotex or Modess  pads per week
- c. Incontinence pads such as Serenity or Poise  pads per week
- d. Disposable undergarment or protective underwear  undergarments per week

Site ID:

Subject ID:

Visit:

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### Teen-LABS (UIF)

5. In the **past 3 months**, have you had treatments for urine leakage?

No  Yes →

5.1 Please specify treatment(s). *Mark "No" or "Yes" to each.*

No   Yes

Medication

Kegel exercises, biofeedback, bladder training (behavioral therapy)

Changes in fluid intake (decrease fluids, stop caffeine)

Other *please describe:* \_\_\_\_\_

6. In the **past 3 months**, how much has your urine leakage **affected your day-to-day activities**?

Not at all    Slightly    Moderately    Quite a bit    Extremely

7. In the **past 3 months**, how much has your urine leakage **bothered** you?

Not at all    Slightly    Moderately    Quite a bit    Extremely

8. Have you had surgery for urine leakage since your bariatric surgery?

No  Yes → When: \_\_\_\_ / \_\_\_\_ (month/year)

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### Teen-LABS (BS) Berlin Sleep Questionnaire

**Form completion date:**  /  /  (mm/dd/yyyy)

Please PRINT NEATLY and complete this form in blue or black INK. Mark response boxes like this:

- |   |   |
|---|---|
| <p>1. Do you snore?<br/> <input type="checkbox"/> No → skip to question 6<br/> <input type="checkbox"/> Yes<br/> <input type="checkbox"/> Don't know → skip to question 6</p> <p>2. Is your snoring:<br/> <input type="checkbox"/> Slightly louder than breathing<br/> <input type="checkbox"/> As loud as talking<br/> <input type="checkbox"/> Louder than talking<br/> <input type="checkbox"/> Very loud. Can be heard in adjacent rooms.<br/> <input type="checkbox"/> Don't know</p> <p>3. How often do you snore?<br/> <input type="checkbox"/> Nearly every day<br/> <input type="checkbox"/> 3 to 4 times a week<br/> <input type="checkbox"/> 1 to 2 times a week<br/> <input type="checkbox"/> 1 to 2 times a month<br/> <input type="checkbox"/> Never or nearly never<br/> <input type="checkbox"/> Don't know</p> <p>4. Has your snoring ever bothered other people?<br/> <input type="checkbox"/> No<br/> <input type="checkbox"/> Yes</p> <p>5. Has anyone noticed that you quit breathing during your sleep?<br/> <input type="checkbox"/> Nearly every day<br/> <input type="checkbox"/> 3 to 4 times a week<br/> <input type="checkbox"/> 1 to 2 times a week<br/> <input type="checkbox"/> 1 to 2 times a month<br/> <input type="checkbox"/> Never or nearly never</p> | <p>6. How often do you feel tired or fatigued after your sleep?<br/> <input type="checkbox"/> Nearly every day<br/> <input type="checkbox"/> 3 to 4 times a week<br/> <input type="checkbox"/> 1 to 2 times a week<br/> <input type="checkbox"/> 1 to 2 times a month<br/> <input type="checkbox"/> Never or nearly never</p> <p>7. During your wake time, do you feel tired, fatigued or not up to par?<br/> <input type="checkbox"/> Nearly every day<br/> <input type="checkbox"/> 3 to 4 times a week<br/> <input type="checkbox"/> 1 to 2 times a week<br/> <input type="checkbox"/> 1 to 2 times a month<br/> <input type="checkbox"/> Never or nearly never</p> <p>8. Have you ever nodded off or fallen asleep while driving a vehicle?<br/> <input type="checkbox"/> N/A, I do not drive.<br/> <input type="checkbox"/> No<br/> <input type="checkbox"/> Yes →</p> |
|---|---|

8.1 How often does this occur?

Nearly every day

3 to 4 times a week

1 to 2 times a week

1 to 2 times a month

Never or nearly never

<b>Site ID:</b> <input type="text"/>	<b>Subject ID:</b> <input type="text"/>	<b>Reviewed by (certification no.):</b> <input type="text"/>	
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### Teen-LABS (RHB) Reproductive Health Baseline

**Form completion date:**  /  / 20 (mm/dd/yyyy)

Please PRINT NEATLY and complete this form in blue or black INK. Mark response boxes like this:

*This form is for females only.*

1. Have you had irregular menstrual periods (less than 8 periods a year) throughout life starting in your teens?  
 No    Yes    I have never had a menstrual period or I have only had menstrual periods for less than a year

2. Have you ever had the following symptoms? (Mark "No" or "Yes" for each.)

No   Yes

- Excess facial, chest, or body hair
- Male pattern baldness, such as thinning of hair at the crown or temple
- Severe acne

3. Has a health care professional ever told you that you have/had polycystic ovary syndrome (PCOS)?

No    Yes →

↓  
Skip to question 4

3.1 Are you currently treating your PCOS?

No    Yes

↓  
Skip to question 4

3.1.1 How are you currently treating your PCOS? (Mark "No" or "Yes" for each.)

No   Yes

- Exercise
- Diet
- Prescription medication

4. In the **past 12 months**, have you taken any hormonal medication, such as hormone replacement therapy (HRT), the pill, or fertility medication?

No    Yes →

↓  
Skip to question 5

4.1 Please indicate which type of hormonal medication you have taken in the **past 12 months**:

- Hormone replacement therapy
- Hormonal birth control (such as pill, ring, shot, Mirena)
- Fertility medication

5. Have you ever had a menstrual period?

No    Yes →

↓  
Skip to question 12

5.1 How old were you when you got your first menstrual period?

years old

	Site ID: <input type="text"/>	Subject ID: <input type="text"/>					
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### Teen-LABS (RHB) Reproductive Health Baseline

Thinking back over the past **12 months**...

6. In how many of those months did you have a menstrual period?

months **If you answered zero (0) months, skip to question 10.**

7. Usually, how many days are between your menstrual periods? (This is the interval from the first day of one menstrual period to the first day of your next menstrual period.)

- Less than 21 days  
 21-35 days  
 More than 35 days  
 Too irregular to estimate

8. On average, how many days did your menstrual period (bleeding) last?

- 1-4 days  
 5-7 days  
 8-9 days  
 More than 9 days

9. Did you have spotting or bleeding that occurred at times other than your menstrual period?

- No  
 Yes →

9.1 In how many of the past 12 months did this occur?

months

10. When was your last menstrual period?

months ago (if less than 3 months ago, go to question 12)

11. If your last period was 3 or more months ago, why did your natural menstrual period stop?

- Birth control or other medication  
 Hysterectomy alone  
 Hysterectomy and oophorectomy  
 Oophorectomy alone  
 Endometrial ablation  
 Chemotherapy  
 Chronic illness  
 Prolactin, adrenal gland or thyroid problem  
 Pregnancy  
 No known reason  
 Other *specify:* \_\_\_\_\_

**12. How old are you now?**

- Under 18 years old → **DO NOT CONTINUE -- END OF QUESTIONNAIRE**  
 18 years old or older

Site ID: <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	Subject ID: <input style="width: 20px; height: 20px;" type="text"/>	
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### Teen-LABS (RHB) Reproductive Health Baseline

**CONTINUE QUESTIONNAIRE ONLY IF SUBJECT IS 18 YEARS OLD OR OLDER**

13. Have you **ever** tried to become pregnant?

- No → *Skip to question 17*
- Yes

14. Has there **ever** been at least 12 months in your life when you were regularly having sexual intercourse with a man and not using any form of birth control and yet you did not become pregnant?

- No     Yes →
- 14.1 Specify age this first happened:  
 \_\_\_\_\_ years old

15. Have you **ever** talked to a doctor or had tests done because of problems becoming pregnant?

- No → *Skip to question 17*
- Yes

16. Have you ever taken any fertility medication to help you become pregnant (such as Clomid, Serophene, Gonal-F, Follistim)?

- No     Yes

17. Total number of times you have been pregnant: \_\_\_\_\_ times ***If you answered zero (0) times, please skip to question 18. If at least one pregnancy,***

Starting with your first pregnancy, please use the table below to report the following:

- your age when you became pregnant
- whether you were taking fertility medication when you became pregnant
- whether you had a live birth, still birth (baby lost after 20 weeks or 5 months), miscarriage (fetus lost before 20 weeks or 5 months), or other outcome.

	your age	fertility med used?		<i>Please mark <b>one</b> outcome per pregnancy</i>			
		No	Yes	live birth	still birth	miscarriage	other outcome
Preg. 1	<input style="width: 20px; height: 20px;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Preg. 2	<input style="width: 20px; height: 20px;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Preg. 3	<input style="width: 20px; height: 20px;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Preg. 4	<input style="width: 20px; height: 20px;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Preg. 5	<input style="width: 20px; height: 20px;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Preg. 6	<input style="width: 20px; height: 20px;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Preg. 7	<input style="width: 20px; height: 20px;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Preg. 8	<input style="width: 20px; height: 20px;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> I have had more than 8 pregnancies							

Site ID:

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### Teen-LABS (RHB) Reproductive Health Baseline

18. In the past 12 months, how often have you used birth control when having sexual intercourse with a man?

- Not sexually active with a man
- Never
- Rarely
- About half the time
- Most of the time
- All of the time

19. In the past 12 months, have you used (or has your partner used) birth control for any reason?

- No    Yes



Skip to  
question 20

19.1 Specify method of birth control you have used in the past 12 months. (Mark "No" or "Yes" for each item.)

No   Yes

- Pills, monthly (including one week of placebo or no pills, get period)
- Pills, continuous use (new pack every 3 weeks, no period)
- Mini Pill, continuous use (progestin only, get period)
- Patch or ring
- Injections of medications (shots) or implantation of a medication release device
- IUD *If yes, specify:*
  - Mirena    Copper
  - Don't know

No   Yes

- Diaphragm
- Cervical cap
- Male or female condom
- Contraceptive foams, creams, jellies
- Natural family planning, rhythm method or having sex during "safe" times
- Withdrawal
- Hysterectomy: your uterus was surgically removed
- Tubal ligation: your tubes were tied
- Vasectomy: your partner was sterilized
- Other, specify: \_\_\_\_\_

20. Please rate how important it is to you to be able to ever become pregnant in the future on a scale from 0 to 10, where 0 is of no importance and 10 is the most important thing in your life.

Enter a number from 0 to 10: \_\_\_\_\_

21. When do you think you will try to become pregnant?

- Never    In next 12 months    In next 13-24 months    After 24 months    Not sure

<b>Site ID:</b> <input type="text"/>	<b>Subject ID:</b> <input type="text"/>	<b>Reviewed by (certification no.):</b> <input type="text"/>	
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**Teen-LABS (RHF) Reproductive Health Follow-up**

**Form completion date:**  /  /  (mm/dd/yyyy)

Please PRINT NEATLY and complete this form in blue or black INK. Mark response boxes like this:

*This form is for females only.*

1. **In the past 12 months**, have you had irregular menstrual periods (less than 8 periods in that time)?

- No
- Yes
- I have never had a menstrual period or I have only had menstrual periods for less than a year

2. **In the past 12 months**, have you had the following symptoms? (Mark "No" or "Yes" for each.)

No   Yes

- Excess facial, chest, or body hair
- Male pattern baldness, such as thinning of hair at the crown or temple
- Severe acne

3. Has a health care professional ever told you that you have/had polycystic ovary syndrome (PCOS)?

No → Go to question 4

Yes →

3.1 Are you currently treating your PCOS?

No → Go to question 4

Yes →

3.1.1 How are you currently treating your PCOS? (Mark "No" or "Yes" for each.)

No   Yes

- a. Exercise
- b. Diet
- c. Prescription medication

4. In the **past 12 months**, have you taken any hormonal medication, such as hormone replacement therapy (HRT), the pill, or fertility medication?

No → Go to question 5

Yes →

4.1 Please indicate which type of hormonal medication you have taken in the **past 12 months**:

- Hormone replacement therapy
- Hormonal birth control (such as pill, ring, shot, Mirena)
- Fertility medication

5. Have you ever had a menstrual period?

No → Go to question 12

Yes →

5.1 How old were you when you got your first menstrual period?

years old

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## Teen-LABS (RHF) Reproductive Health Follow-up

Thinking back over the past **12 months**...

6. In how many of those months did you have a menstrual period?

months *If you answered zero (0) months, go to question 10.*

7. Usually, how many days are between your menstrual periods? (This is the interval from the first day of one menstrual period to the first day of your next menstrual period.)

Less than 21 days    21-35 days    More than 35 days    Too irregular to estimate

8. On average, how many days did your menstrual period (bleeding) last?

1-4 days    5-7 days    8-9 days    More than 9 days

9. Did you have spotting or bleeding that occurred at times other than your menstrual period?

No → *Go to question 12*

Yes → 9.1 In how many of the past 12 months did this occur?

months

10. When was your last menstrual period?

months ago *If you answered less than 3 months ago, go to question 12.*

11. If your last period was 3 or more months ago, why did your natural menstrual period stop?

Hysterectomy and oophorectomy (uterus and both ovaries removed)

Oophorectomy alone (both ovaries removed, uterus not removed)

Endometrial ablation (lining of uterus destroyed, uterus not removed)

Hysterectomy alone (uterus removed, not both ovaries removed)

Birth control or other medication

Chemotherapy

Chronic illness

Prolactin, adrenal gland or thyroid problem

Pregnancy

Breast feeding

No known reason

Other, specify:

*If you marked one of these choices,  
you are done with this questionnaire.  
Please do not answer the remainder of  
this questionnaire.*

12. How old are you now?

Under 18 years old → **DO NOT CONTINUE -- END OF QUESTIONNAIRE**

18 years old or older

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### Teen-LABS (RHF) Reproductive Health Follow-up

**CONTINUE QUESTIONNAIRE ONLY IF SUBJECT IS 18 YEARS OLD OR OLDER**

13. In the **past 12 months**, have you regularly been having sexual intercourse with a man and not used any form of birth control and yet you did not become pregnant?

- No  
 Yes

14. In the **past 12 months**, how often have you used birth control when having sexual intercourse with a man?

- Not sexually active with a man  
 Never  
 Rarely  
 About half the time  
 Most of the time  
 All of the time

15. In the **past 12 months**, have you (or has your partner) used birth control for any reason?

No → *Go to question 16*

Yes →

15.1 Specify method of birth control you have used in the **past 12 months**. (Mark "No" or "Yes" for each item.)

No Yes

- a. Pills, monthly (including one week of placebo or no pills, get period)  
  b. Pills, continuous use (new pack every 3 weeks, no period)  
  c. Mini Pill, continuous use (progestin only, get period)  
  d. Patch or ring  
  e. Injections of medications (shots) or implantation of a medication release device  
  f. IUD  
↳ *If yes, specify:*  Mirena  Copper  Don't know  
  g. Diaphragm  
  h. Cervical cap  
  i. Male or female condom  
  j. Contraceptive foams, creams, jellies  
  k. Natural family planning, rhythm method or having sex during "safe" times  
  l. Withdrawal  
  m. Tubal ligation: your tubes were tied  
  n. Vasectomy: your partner was sterilized  
  o. Other, specify:

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### Teen-LABS (RHF) Reproductive Health Follow-up

16. Have you tried to become pregnant in the **past 12 months**?

No → Go to question 19

Yes

17. In the **past 12 months**, have you talked to a doctor or had tests done because of problems becoming pregnant?

No → Go to question 19

Yes

18. In the **past 12 months**, have you taken any fertility medication to help you become pregnant (such as Clomid, Serophene, Gonal-F, Follistim)?

No

Yes

19. Since having bariatric surgery, how many times have you been pregnant?

times *If zero (0), go to question 22.*

20. Are you currently pregnant?

No

Yes → 20.1 What is your due date? (*If you do not know exact date, complete month and year.*)

/  /   
mm      dd      yy

20.2 Were you on fertility treatment when you became pregnant?

No

Yes

21. In the **past 12 months**, have you had any pregnancies **end** (due to miscarriage, ectopic or tubal pregnancy, abortion, still birth, or live birth)?

No

Yes → 21.1 How many pregnancies have ended in the **past 12 months**?

times

22. Please rate how important it is to you to be able to ever become pregnant in the future on a scale from 0 to 10, where 0 is of no importance and 10 is the most important thing in your life.

Enter a number from 0 to 10:

23. When do you think you will try to become pregnant?

Never    In next 12 months    In next 13-24 months    After 24 months    Not sure

<b>Site ID:</b> <input style="width: 30px;" type="text"/>	<b>Subject ID:</b> <input style="width: 30px;" type="text"/>	<b>Reviewed by (certification no.):</b> <input style="width: 30px;" type="text"/>	
<b>Visit:</b> <input style="width: 30px;" type="text"/>	<b>For coordinator use only.</b>	<b>Review date:</b> <input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/>	

### Teen-LABS (MAB) Medical Assessment Baseline

**Form completion date:**  /  /  (mm/dd/yyyy)

Please PRINT NEATLY and complete this form in blue or black INK. Mark response boxes like this:

*The following set of questions asks about various medical conditions that you may or may not have had.*

- |   |                          |                          |
|---|--------------------------|--------------------------|
| 1. Have you ever had surgery on... (Mark "No" or "Yes" for each.)                     | <u>No</u>                | <u>Yes</u>               |
| 1.1 your back, such as disc surgery, laminectomy, or fusion surgery?                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 1.2 your hip(s), such as joint replacement, reconstructive or arthroscopic surgery?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 1.3 your knee(s), such as joint replacement, reconstructive or arthroscopic surgery?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 1.4 your ankle(s), such as joint replacement, reconstructive or arthroscopic surgery? | <input type="checkbox"/> | <input type="checkbox"/> |

2. In the **past 4 weeks**, have you suffered from back or leg pain, such as pain that radiates or shoots down the back of the leg to the knee or foot?

- No     Yes
- ↓            ↓

*Skip to  
page 2*

2.1 In the **past 4 weeks**, how bothersome have each of the following symptoms been?

	Not at all bothersome	Slightly bothersome	Moderately bothersome	Very bothersome	Extremely bothersome
a. Back pain:	<input type="checkbox"/>				
b. Leg pain:	<input type="checkbox"/>				

2.2 In the **past 4 weeks**, how much did pain interfere with your normal work, including both work outside the home and house work?

Not at all     A little bit     Moderately     Quite a bit     Extremely

2.3 If you had to spend the rest of your life with the symptoms you have right now, how would you feel about it?

Very dissatisfied	Dissatisfied	Somewhat dissatisfied	Neither satisfied nor dissatisfied	Somewhat satisfied	Satisfied	Very satisfied
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2.4 In the **past 4 weeks**, about how many days did you cut down on the things you usually do for more than half the day because of back pain or leg pain? Please note that there are 28 days in 4 weeks.

number of days

2.5 In the **past 4 weeks**, how many days did low back pain or leg pain keep you from going to school or work? Please note that there are 28 days in 4 weeks.

number of days (write "-2" if you did not go to work or school in the past 4 weeks)

Site ID: Subject ID: 

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**Teen-LABS (MAB) Medical Assessment Baseline***In this section we are interested in learning how your weight affects your ability to function in daily life.*

3A. Please mark the response which best describes your usual abilities OVER THE PAST WEEK:

	Without ANY difficulty	With SOME difficulty	With MUCH difficulty	UNABLE to do
<b>DRESSING &amp; GROOMING</b>				
Are you able to:				
1. Dress yourself, including tying shoelaces and doing buttons?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Shampoo your hair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>ARISING</b>				
Are you able to:				
1. Stand up from a straight chair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Get in and out of bed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>EATING</b>				
Are you able to:				
1. Cut your meat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Lift a full cup or glass to your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Open a new milk carton?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>WALKING</b>				
Are you able to:				
1. Walk outdoors on a flat ground?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Climb up five steps?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3B. Please mark any AIDS OR DEVICES that you usually use for any of these activities (*mark all that apply*):

- Cane                       Devices used for dressing (button hook, zipper pull, long-handled shoe horn, etc.)  
 Walker                       Built up or special utensils  
 Crutches                       Special or built up chair  
 Wheelchair                       Other, specify:

3C. Please mark any categories for which you usually need HELP FROM ANOTHER PERSON (*mark all that apply*):

- Dressing and Grooming  
 Arising  
 Eating  
 Walking

Site ID: Subject ID: 

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**Teen-LABS (MAB) Medical Assessment Baseline**

3D. Please mark the response which best describes your usual abilities OVER THE PAST WEEK:

	Without ANY difficulty	With SOME difficulty	With MUCH difficulty	UNABLE to do
<b>HYGIENE</b>				
Are you able to:				
1. Wash and dry your body?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Take a tub bath?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Get on and off the toilet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>REACH</b>				
Are you able to:				
1. Reach and get down a 5-pound object (such as a bag of sugar) from just above your head?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Bend down to pick up clothing from the floor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>GRIP</b>				
Are you able to:				
1. Open car doors?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Open jars which have been previously opened?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Turn faucets on and off?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>ACTIVITIES</b>				
Are you able to:				
1. Run errands and shop?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Get in and out of a car?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do chores such as vacuuming or yardwork?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3E. Please mark any AIDS OR DEVICES that you usually use for any of these activities (*mark all that apply*):

- Raised toilet seat                       Bathtub bar  
 Bathtub seat                               Long-handled appliances for reach  
 Jar opener (for jars previously opened)     Long-handled appliances in bathroom  
 Other, specify:

3F. Please mark any categories for which you usually need HELP FROM ANOTHER PERSON (*mark all that apply*):

- Hygiene  
 Reach  
 Gripping and opening things  
 Errands and chores

Site ID:

Subject ID:

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**Teen-LABS (MAB) Medical Assessment Baseline***We are also interested in learning whether or not you are affected by pain because of your weight.*

3G. How much pain have you had because of your weight IN THE PAST WEEK? Please rate the pain on a scale from 0 to 10 where 0 is no pain and 10 is severe pain.

NO PAIN	<input type="checkbox"/>	SEVERE PAIN										
	0	1	2	3	4	5	6	7	8	9	10	

3H. How much pain have you had in your LOWER BACK because of your weight IN THE PAST WEEK? Please rate the pain on a scale from 0 to 10 where 0 is no pain and 10 is severe pain.

NO PAIN	<input type="checkbox"/>	SEVERE PAIN										
	0	1	2	3	4	5	6	7	8	9	10	

3I. How much pain have you had in your HIP(S) because of your weight IN THE PAST WEEK? Please rate the pain on a scale from 0 to 10 where 0 is no pain and 10 is severe pain.

NO PAIN	<input type="checkbox"/>	SEVERE PAIN										
	0	1	2	3	4	5	6	7	8	9	10	

3J. How much pain have you had in you KNEE(S) because of your weight IN THE PAST WEEK? Please rate the pain on a scale from 0 to 10 where 0 is no pain and 10 is severe pain.

NO PAIN	<input type="checkbox"/>	SEVERE PAIN										
	0	1	2	3	4	5	6	7	8	9	10	

3K. How much pain have you had in your ANKLE(S) and/or FEET because of your weight IN THE PAST WEEK? Please rate the pain on a scale from 0 to 10 where 0 is no pain and 10 is severe pain.

NO PAIN	<input type="checkbox"/>	SEVERE PAIN										
	0	1	2	3	4	5	6	7	8	9	10	

Site ID: Subject ID: 

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## Teen-LABS (MAB) Medical Assessment Baseline

4. Can you walk, assisted or unassisted?

 No, I can NOT walk at all     Yes, I CAN walkSkip to  
question 5

4.1 Mark the description below that best characterizes your walking ability.

- I can walk 200ft (length of a grocery store aisle) unassisted.
- I can walk 200ft with an assistive device (such as a cane or walker).
- I cannot walk 200ft with an assistive device.

4.2 Do you **currently** use any of the following to aid with walking? (Mark "No" or "Yes" to each, if Yes, specify how often)

	No	Yes	If yes, how often?	Rarely (less than once per week)	Sometimes (about 3 times per week)	Often (almost every day)	Always (I can't walk without it)
a. A wheelchair	<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. A walker	<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. A cane	<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. Have you **ever** had surgery for acid reflux, heartburn, or a hiatal hernia? No     Yes6. Have you **ever** had surgery to remove your gallbladder? No     Yes → Skip to question 76.1 In the **past 3 months**, have you had upper abdominal pain shortly after eating food? No     Yes7. Have you **ever** been told by a doctor or other health care professional that you had a blood clot of the **lung(s) also known as a pulmonary embolism (PE)** requiring blood thinners? No     Yes8. Have you **ever** been told by a doctor or other health care professional that you had a blood clot of the **leg(s) also known as deep phlebitis, deep vein thrombosis, or DVT** requiring blood thinners? No     Yes9. Have you **ever** been told by a doctor or other health care professional that you had a myocardial infarction or heart attack? No     Yes → 9.1 Was it within the past year?  No     YesSkip to  
question 10

Site ID: Subject ID: 

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## Teen-LABS (MAB) Medical Assessment Baseline

10. Are you **currently** using supplemental oxygen such as an oxygen tank to help you breathe? No  YesSkip to  
question 11

10.1 How often do you use supplemental oxygen such as an oxygen tank to help you breathe?

<b>Rarely</b> <i>(less than once per week)</i>	<b>Sometimes</b> <i>(about 3 times per week)</i>	<b>Often</b> <i>(almost every day)</i>	<b>Always</b> <i>(I can't breathe without it)</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. Have you ever been told by a doctor or other health care professional that you have asthma?

 No  YesSkip to  
question 1211.1 In the **past 4 weeks**, how much of the time did your **asthma** keep you from getting as much done at work, school, or at home? All of the time  Most of the time  Some of the time  A little of the time  None of the time11.2 During the **past 4 weeks**, how often have you had shortness of breath? More than once a day  Once a day  3 to 6 times a week  Once or twice a week  Not at all11.3 During the **past 4 weeks**, how often did your asthma symptoms (wheezing, coughing, shortness of breath, chest tightness, or pain) wake you up at night or earlier than usual in the morning? 4 or more nights a week  2 or 3 nights a week  Once a week  Once or twice  Not at all11.4 During the **past 4 weeks**, how often have you used your rescue inhaler or nebulizer medication (such as albuterol)?

3 or more times a day	1 or 2 times per day	2 or 3 times per week	Once a week or less	Not at all
<input type="checkbox"/>				

11.5 How would you rate your **asthma** control during the **past 4 weeks**?

Not controlled at all	Poorly controlled	Somewhat controlled	Well controlled	Completely controlled
<input type="checkbox"/>				

11.6 Have you **ever** been intubated (had a breathing tube placed) or undergone mechanical ventilation (been placed on a respirator) because of your asthma? No  Yes

Copyright 2002, by QualityMetric Incorporated. Asthma Control Test is a trademark of QualityMetric Incorporated. The Asthma Control Test™ is for people with asthma 12 years and older.

12. Have you ever had a kidney stone?

 No  Yes

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### Teen-LABS (MAB) Medical Assessment Baseline

13. Have you experienced low blood sugar in the **past 3 months**?

- Don't know → *Skip to*  
 No → *question 14*  
 Yes →

*If yes,*

13.1 How many times during the **last 7 days** did you think that you had low blood sugar?

times

13.2 In general, do your low blood sugars typically happen (*mark one*):

- 4 hours or less after a meal or snack  
 More than 4 hours after a meal or snack  
 There is no typical relationship to meals or snacks

13.3 Have you generally had any of the following symptoms during your episode of low blood sugar?  
(*Mark "Yes" or "No" for each.*)

- | <u>No</u>                | <u>Yes</u>               |                   | <u>No</u>                | <u>Yes</u>               |                              |
|--------------------------|--------------------------|-------------------|--------------------------|--------------------------|------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | a. Hunger         | <input type="checkbox"/> | <input type="checkbox"/> | f. Dizziness                 |
| <input type="checkbox"/> | <input type="checkbox"/> | b. Anxiousness    | <input type="checkbox"/> | <input type="checkbox"/> | g. Trouble concentrating     |
| <input type="checkbox"/> | <input type="checkbox"/> | c. Sweating       | <input type="checkbox"/> | <input type="checkbox"/> | h. Trouble remembering words |
| <input type="checkbox"/> | <input type="checkbox"/> | d. Heart pounding | <input type="checkbox"/> | <input type="checkbox"/> | i. Blackouts                 |
| <input type="checkbox"/> | <input type="checkbox"/> | e. Shakiness      |                          |                          |                              |

13.4 **In the past 3 months**, how many times was your low blood sugar so severe that you needed someone to help you (including a visit to the ER or hospitalization)?

times

13.5 Was your blood sugar checked during the most severe episode of low blood sugar during the **past 3 months**?

- No  Yes → 13.5.1 What was the glucose value?  mg/dL

Source: Look AHEAD (Action For Health in Diabetes) Study.

Site ID: Subject ID: 

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## Teen-LABS (MAB) Medical Assessment Baseline

14. Do you **currently** have diabetes? No  YesSkip to  
question 1514.1 How long have you had diabetes?  years and/or  months14.2 Are you **currently** taking medications for diabetes? (Mark "No" or "Yes" for each.)

	No	Yes	If Yes,	
a. Oral diabetes medication	<input type="checkbox"/>	<input type="checkbox"/>	→	14.2.1 How many years have you been taking oral diabetes medication? <input type="text"/> years and/or <input type="text"/> months
b. Insulin	<input type="checkbox"/>	<input type="checkbox"/>	→	14.2.2 How many total units of insulin do you currently inject each day? <input type="text"/> units/day 14.2.3 How many total years have you been taking injections (insulin and/or non-insulin) for diabetes? <input type="text"/> years and/or <input type="text"/> months
c. Non-insulin injectable (e.g., Byetta (exenatide) or Symlin (pramlintide))	<input type="checkbox"/>	<input type="checkbox"/>	→	14.2.4 How many total units of non-insulin do you currently inject each day? <input type="text"/> units/day 14.2.5 How many total years have you been taking injections (insulin and/or non-insulin) for diabetes? <input type="text"/> years and/or <input type="text"/> months

14.3 Have you **ever** required hospitalization for treatment of a diabetes complication? No  Yes

14.3.1 During your hospitalization, were you treated for any of the following due to diabetes? (Mark "No" or "Yes" to each. If Yes, specify if it occurred within the past 12 months.)

Did this occur within  
the **last 12 months**?

	No	Yes	If Yes,	No	Yes
a. Very high blood sugar or coma	<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="checkbox"/>	<input type="checkbox"/>
b. Ketoacidosis	<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="checkbox"/>	<input type="checkbox"/>
c. Severe skin infection (cellulitis)	<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="checkbox"/>	<input type="checkbox"/>
d. Low blood flow to the toes, foot, or leg (claudication)	<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="checkbox"/>	<input type="checkbox"/>
e. Amputation of the toes, foot, or leg	<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="checkbox"/>	<input type="checkbox"/>
f. Nausea and vomiting due to gastroparesis	<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="checkbox"/>	<input type="checkbox"/>
g. Kidney failure or other kidney complication	<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="checkbox"/>	<input type="checkbox"/>
h. Other, specify:	<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="checkbox"/>	<input type="checkbox"/>

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## Teen-LABS (MAB) Medical Assessment Baseline

15. In the last 12 months, have you been treated for a nutritional deficiency?

 No  Yes →↓  
Skip to  
question 16

15.1 Which nutrients? (Mark "No" or "Yes" to each.)

<u>No</u>	<u>Yes</u>	<u>No</u>	<u>Yes</u>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

16. In the last 12 months, have you experienced a fracture or broken bone?

 No  Yes →16.1 Was there a definite injury involved?  No  Yes

17. In the last 12 months, have you noticed a definite change in your memory?

 No  Yes →17.1 Has your memory gotten worse or better?  Worse  Better

18. In the last 12 months, have you experienced unusual hair loss to the point of being noticed by others or requiring a wig?

 No  Yes

19. In the last 12 months, have you experienced any changes or abnormality of your skin?

 No  Yes

20. This next set of questions asks about the feeling in your legs and feet. Mark "No" or "Yes" based on how you usually feel.

	<u>No</u>	<u>Yes</u>
20.1 Are your legs and/or feet numb?	<input type="checkbox"/>	<input type="checkbox"/>
20.2 Do you ever have any burning pain in your legs and/or feet?	<input type="checkbox"/>	<input type="checkbox"/>
20.3 Are your feet too sensitive to touch?	<input type="checkbox"/>	<input type="checkbox"/>
20.4 Do you get muscle cramps in your legs and/or feet?	<input type="checkbox"/>	<input type="checkbox"/>
20.5 Do you ever have any prickling feelings in your legs or feet?	<input type="checkbox"/>	<input type="checkbox"/>
20.6 Does it hurt when the bed covers touch your skin?	<input type="checkbox"/>	<input type="checkbox"/>
20.7 When you get into the tub or shower, are you able to tell hot water from the cold water?	<input type="checkbox"/>	<input type="checkbox"/>
20.8 Have you ever had an open sore on your foot?	<input type="checkbox"/>	<input type="checkbox"/>
20.9 Has your doctor ever told you that you have diabetic neuropathy?	<input type="checkbox"/>	<input type="checkbox"/>
20.10 Do you feel weak all over most of the time?	<input type="checkbox"/>	<input type="checkbox"/>
20.11 Are your symptoms worse at night?	<input type="checkbox"/>	<input type="checkbox"/>
20.12 Do your legs hurt when you walk?	<input type="checkbox"/>	<input type="checkbox"/>
20.13 Are you able to sense your feet when you walk?	<input type="checkbox"/>	<input type="checkbox"/>
20.14 Is the skin on your feet so dry that it cracks open?	<input type="checkbox"/>	<input type="checkbox"/>
20.15 Have you ever had an amputation?	<input type="checkbox"/>	<input type="checkbox"/>

Source: Michigan Diabetes Research and Training Center, [www.med.umich.edu/mdrtc/survey/index.htm](http://www.med.umich.edu/mdrtc/survey/index.htm).

<b>Site ID:</b> <input type="text"/>	<b>Subject ID:</b> <input type="text"/>	<b>Reviewed by (certification no.):</b> <input type="text"/>	
<b>Visit:</b> <input type="text"/>	<b>For coordinator use only.</b>	<b>Review date:</b> <input type="text"/> / <input type="text"/> / <input type="text"/>	

**Teen-LABS (MAF) Medical Assessment Follow-up**

**Form completion date:**  /  /  (mm/dd/yyyy)

Please PRINT NEATLY and complete this form in blue or black INK. Mark response boxes like this:

**Some questions on this form will you ask about events that happened *since your last study visit*. By that, we mean the following:**

- If this is your 6 or 12 month visit, answer those questions about "*the past 6 months*."
- If this is your 24 month visit, or a subsequent annual follow-up, answer those questions about "*the past 12 months*."

Use these time frames even if you missed a scheduled follow-up visit.

*The following set of questions asks about various medical conditions that you may or may not have had.*

1. **Since your last study visit**, have you had surgery on... (Mark "No" or "Yes" for each.) No Yes
- |   |                          |                          |
|---|--------------------------|--------------------------|
| 1.1 your back, such as disc surgery, laminectomy, or fusion surgery?                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 1.2 your hip(s), such as joint replacement, reconstructive or arthroscopic surgery?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 1.3 your knee(s), such as joint replacement, reconstructive or arthroscopic surgery?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 1.4 your ankle(s), such as joint replacement, reconstructive or arthroscopic surgery? | <input type="checkbox"/> | <input type="checkbox"/> |

2. In the **past 4 weeks**, have you suffered from back or leg pain, such as pain that radiates or shoots down the back of the leg to the knee or foot?

No     Yes



*Skip to page 2*

2.1 In the **past 4 weeks**, how bothersome have each of the following symptoms been?

	Not at all bothersome	Slightly bothersome	Moderately bothersome	Very bothersome	Extremely bothersome
a. Back pain:	<input type="checkbox"/>				
b. Leg pain:	<input type="checkbox"/>				

2.2 In the **past 4 weeks**, how much did pain interfere with your normal work, including both work outside the home and house work?

Not at all     A little bit     Moderately     Quite a bit     Extremely

2.3 If you had to spend the rest of your life with the symptoms you have right now, how would you feel about it?

Very dissatisfied	Dissatisfied	Somewhat dissatisfied	Neither satisfied nor dissatisfied	Somewhat satisfied	Satisfied	Very satisfied
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2.4 In the **past 4 weeks**, about how many days did you cut down on the things you usually do for more than half the day because of back pain or leg pain? Please note that there are 28 days in 4 weeks.

number of days

2.5 In the **past 4 weeks**, how many days did low back pain or leg pain keep you from going to school or work? Please note that there are 28 days in 4 weeks.

number of days (write "-2" if you did not go to work or school in the past 4 weeks)

Site ID: <input style="width: 40px; height: 20px;" type="text"/>	Subject ID: <input style="width: 80px; height: 20px;" type="text"/>	
Visit: <input style="width: 40px; height: 20px;" type="text"/>	<b>For coordinator use only.</b>	

**Teen-LABS (MAF) Medical Assessment Follow-up**

*In this section we are interested in learning how your weight affects your ability to function in daily life.*

3A. Please mark the response which best describes your usual abilities OVER THE PAST WEEK:

	Without ANY difficulty	With SOME difficulty	With MUCH difficulty	UNABLE to do
<b>DRESSING &amp; GROOMING</b>				
Are you able to:				
1. Dress yourself, including tying shoelaces and doing buttons?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Shampoo your hair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>ARISING</b>				
Are you able to:				
1. Stand up from a straight chair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Get in and out of bed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>EATING</b>				
Are you able to:				
1. Cut your meat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Lift a full cup or glass to your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Open a new milk carton?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>WALKING</b>				
Are you able to:				
1. Walk outdoors on a flat ground?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Climb up five steps?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3B. Please mark any AIDS OR DEVICES that you usually use for any of these activities (*mark all that apply*):

- |                                     |   |
|-------------------------------------|---|
| <input type="checkbox"/> Cane       | <input type="checkbox"/> Devices used for dressing (button hook, zipper pull, long-handled shoe horn, etc.) |
| <input type="checkbox"/> Walker     | <input type="checkbox"/> Built up or special utensils   |
| <input type="checkbox"/> Crutches   | <input type="checkbox"/> Special or built up chair  |
| <input type="checkbox"/> Wheelchair | <input type="checkbox"/> Other, specify: <input style="width: 400px; height: 25px;" type="text"/>           |

3C. Please mark any categories for which you usually need HELP FROM ANOTHER PERSON (*mark all that apply*):

- Dressing and Grooming
- Arising
- Eating
- Walking

Site ID: Subject ID: Visit: 

For coordinator use only.

**Teen-LABS (MAF) Medical Assessment Follow-up**

3D. Please mark the response which best describes your usual abilities OVER THE PAST WEEK:

	Without ANY difficulty	With SOME difficulty	With MUCH difficulty	UNABLE to do
<b>HYGIENE</b>				
Are you able to:				
1. Wash and dry your body?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Take a tub bath?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Get on and off the toilet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>REACH</b>				
Are you able to:				
1. Reach and get down a 5-pound object (such as a bag of sugar) from just above your head?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Bend down to pick up clothing from the floor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>GRIP</b>				
Are you able to:				
1. Open car doors?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Open jars which have been previously opened?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Turn faucets on and off?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>ACTIVITIES</b>				
Are you able to:				
1. Run errands and shop?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Get in and out of a car?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do chores such as vacuuming or yardwork?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3E. Please mark any AIDS OR DEVICES that you usually use for any of these activities (*mark all that apply*):

- Raised toilet seat                       Bathtub bar  
 Bathtub seat                               Long-handled appliances for reach  
 Jar opener (for jars previously opened)     Long-handled appliances in bathroom  
 Other, specify:

3F. Please mark any categories for which you usually need HELP FROM ANOTHER PERSON (*mark all that apply*):

- Hygiene  
 Reach  
 Gripping and opening things  
 Errands and chores

Site ID:

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Visit:

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**Teen-LABS (MAF) Medical Assessment Follow-up**

*We are also interested in learning whether or not you are affected by pain because of your weight.*

3G. How much pain have you had because of your weight IN THE PAST WEEK? Please rate the pain on a scale from 0 to 10 where 0 is no pain and 10 is severe pain.

NO PAIN                                                SEVERE PAIN  
                  0           1           2           3           4           5           6           7           8           9           10

3H. How much pain have you had in your LOWER BACK because of your weight IN THE PAST WEEK? Please rate the pain on a scale from 0 to 10 where 0 is no pain and 10 is severe pain.

NO PAIN                                                SEVERE PAIN  
                  0           1           2           3           4           5           6           7           8           9           10

3I. How much pain have you had in your HIP(S) because of your weight IN THE PAST WEEK? Please rate the pain on a scale from 0 to 10 where 0 is no pain and 10 is severe pain.

NO PAIN                                                SEVERE PAIN  
                  0           1           2           3           4           5           6           7           8           9           10

3J. How much pain have you had in you KNEE(S) because of your weight IN THE PAST WEEK? Please rate the pain on a scale from 0 to 10 where 0 is no pain and 10 is severe pain.

NO PAIN                                                SEVERE PAIN  
                  0           1           2           3           4           5           6           7           8           9           10

3K. How much pain have you had in your ANKLE(S) and/or FEET because of your weight IN THE PAST WEEK? Please rate the pain on a scale from 0 to 10 where 0 is no pain and 10 is severe pain.

NO PAIN                                                SEVERE PAIN  
                  0           1           2           3           4           5           6           7           8           9           10

Site ID:

Subject ID:

Visit:

For coordinator use only.

### Teen-LABS (MAF) Medical Assessment Follow-up

4. Can you walk, assisted or unassisted?

No, I can NOT walk at all     Yes, I CAN walk



Skip to question 5



4.1 Mark the description below that best characterizes your walking ability.

- I can walk 200ft (length of a grocery store aisle) unassisted.
- I can walk 200ft with an assistive device (such as a cane or walker).
- I cannot walk 200ft with an assistive device.

4.2 Do you **currently** use any of the following to aid with walking? (Mark "No" or "Yes" to each, if Yes, specify how often)

	If yes, how often?		Rarely (less than once per week)	Sometimes (about 3 times per week)	Often (almost every day)	Always (I can't walk without it)
	No	Yes				
a. A wheelchair	<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. A walker	<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. A cane	<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. *Since your last study visit*, have you had surgery for acid reflux, heartburn, or a hiatal hernia?

No     Yes

6. *Since your last study visit*, have you had surgery to remove your gallbladder?

No     Yes → Skip to question 7



6.1 In the **past 3 months**, have you had upper abdominal pain shortly after eating food?     No     Yes

7. *Since your last study visit*, have you been told by a doctor or other health care professional that you had a blood clot of the **lung(s) also known as a pulmonary embolism (PE)** requiring blood thinners?

No     Yes

8. *Since your last study visit*, have you been told by a doctor or other health care professional that you had a blood clot of the **leg(s) also known as deep phlebitis, deep vein thrombosis, or DVT** requiring blood thinners?

No     Yes

9. *Since your last study visit*, have you been told by a doctor or other health care professional that you had a myocardial infarction or heart attack?

No     Yes

10. Are you **currently** using supplemental oxygen such as an oxygen tank to help you breathe?

No     Yes →



Skip to question 11

10.1 How often do you use supplemental oxygen such as an oxygen tank to help you breathe?

Rarely (less than once per week)	Sometimes (about 3 times per week)	Often (almost every day)	Always (I can't breathe without it)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Site ID:

Subject ID:

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### Teen-LABS (MAF) Medical Assessment Follow-up

11. *Since your last study visit*, have you been told by a doctor or other health care professional that you have asthma?

No  Yes



*Skip to  
question 12*

11.1 In the **past 4 weeks**, how much of the time did your **asthma** keep you from getting as much done at work, school, or at home?

All of the time  Most of the time  Some of the time  A little of the time  None of the time

11.2 During the **past 4 weeks**, how often have you had shortness of breath?

More than once a day  Once a day  3 to 6 times a week  Once or twice a week  Not at all

11.3 During the **past 4 weeks**, how often did your asthma symptoms (wheezing, coughing, shortness of breath, chest tightness, or pain) wake you up at night or earlier than usual in the morning?

4 or more nights a week  2 or 3 nights a week  Once a week  Once or twice  Not at all

11.4 During the **past 4 weeks**, how often have you used your rescue inhaler or nebulizer medication (such as albuterol)?

3 or more times a day  1 or 2 times per day  2 or 3 times per week  Once a week or less  Not at all

11.5 How would you rate your **asthma** control during the **past 4 weeks**?

Not controlled at all  Poorly controlled  Somewhat controlled  Well controlled  Completely controlled

11.6 Have you **ever** been intubated (had a breathing tube placed) or undergone mechanical ventilation (been placed on a respirator) because of your asthma?

No  Yes

Copyright 2002, by QualityMetric Incorporated. Asthma Control Test is a trademark of QualityMetric Incorporated. The Asthma Control Test™ is for people with asthma 12 years and older.

12. *Since your last study visit*, have you had a kidney stone?

No  Yes

Site ID:

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### Teen-LABS (MAF) Medical Assessment Follow-up

13. Have you experienced low blood sugar in the **past 3 months**?

- Don't know → *Skip to*  
 No → *question 14*  
 Yes →

*If yes,*

13.1 How many times during the **last 7 days** did you think that you had low blood sugar?

times

13.2 In general, do your low blood sugars typically happen (*mark one*):

- 4 hours or less after a meal or snack  
 More than 4 hours after a meal or snack  
 There is no typical relationship to meals or snacks

13.3 Have you generally had any of the following symptoms during your episode of low blood sugar?  
(*Mark "Yes" or "No" for each.*)

- | <u>No</u>                | <u>Yes</u>               |                   | <u>No</u>                | <u>Yes</u>               |                              |
|--------------------------|--------------------------|-------------------|--------------------------|--------------------------|------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | a. Hunger         | <input type="checkbox"/> | <input type="checkbox"/> | f. Dizziness                 |
| <input type="checkbox"/> | <input type="checkbox"/> | b. Anxiousness    | <input type="checkbox"/> | <input type="checkbox"/> | g. Trouble concentrating     |
| <input type="checkbox"/> | <input type="checkbox"/> | c. Sweating       | <input type="checkbox"/> | <input type="checkbox"/> | h. Trouble remembering words |
| <input type="checkbox"/> | <input type="checkbox"/> | d. Heart pounding | <input type="checkbox"/> | <input type="checkbox"/> | i. Blackouts                 |
| <input type="checkbox"/> | <input type="checkbox"/> | e. Shakiness      |                          |                          |                              |

13.4 **In the past 3 months**, how many times was your low blood sugar so severe that you needed someone to help you (including a visit to the ER or hospitalization)?

times

13.5 Was your blood sugar checked during the most severe episode of low blood sugar in the **past 3 months**?

- No  Yes → 13.5.1 What was the glucose value?  mg/dL

Source: Look AHEAD (Action For Health in Diabetes) Study.



Site ID: Subject ID: Visit: 

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**Teen-LABS (MAF) Medical Assessment Follow-up**16. *Since your last study visit*, have you experienced a fracture or broken bone? No  Yes → 16.1 Was there a definite injury involved?  No  Yes17. *Since your last study visit*, have you noticed a definite change in your memory? No  Yes → 17.1 Has your memory gotten worse or better?  Worse  Better18. *Since your last study visit*, have you experienced unusual hair loss to the point of being noticed by others or requiring a wig? No  Yes19. *Since your last study visit*, have you experienced any changes or abnormality of your skin? No  Yes

20. This next set of questions asks about the feeling in your legs and feet. Mark "No" or "Yes" based on how you usually feel.

	No	Yes
20.1 Are your legs and/or feet numb?	<input type="checkbox"/>	<input type="checkbox"/>
20.2 Do you ever have any burning pain in your legs and/or feet?	<input type="checkbox"/>	<input type="checkbox"/>
20.3 Are your feet too sensitive to touch?	<input type="checkbox"/>	<input type="checkbox"/>
20.4 Do you get muscle cramps in your legs and/or feet?	<input type="checkbox"/>	<input type="checkbox"/>
20.5 Do you ever have any prickling feelings in your legs or feet?	<input type="checkbox"/>	<input type="checkbox"/>
20.6 Does it hurt when the bed covers touch your skin?	<input type="checkbox"/>	<input type="checkbox"/>
20.7 When you get into the tub or shower, are you able to tell hot water from the cold water?	<input type="checkbox"/>	<input type="checkbox"/>
20.8 Have you ever had an open sore on your foot?	<input type="checkbox"/>	<input type="checkbox"/>
20.9 Has your doctor ever told you that you have diabetic neuropathy?	<input type="checkbox"/>	<input type="checkbox"/>
20.10 Do you feel weak all over most of the time?	<input type="checkbox"/>	<input type="checkbox"/>
20.11 Are your symptoms worse at night?	<input type="checkbox"/>	<input type="checkbox"/>
20.12 Do your legs hurt when you walk?	<input type="checkbox"/>	<input type="checkbox"/>
20.13 Are you able to sense your feet when you walk?	<input type="checkbox"/>	<input type="checkbox"/>
20.14 Is the skin on your feet so dry that it cracks open?	<input type="checkbox"/>	<input type="checkbox"/>
20.15 Have you ever had an amputation?	<input type="checkbox"/>	<input type="checkbox"/>

Source: Michigan Diabetes Research and Training Center, [www.med.umich.edu/mdrtc/survey/index.htm](http://www.med.umich.edu/mdrtc/survey/index.htm).

21. *Since your last study visit*, have you been hospitalized? No  Yes → 21.1 Did this hospitalization occur in the **last 6 months**?  No  Yes22. *Since your last study visit*, have you had any out-patient procedures? No  Yes → 22.1 Did this out-patient procedure occur in the **last 6 months**?  No  Yes

<b>Site ID:</b> <input type="text"/>	<b>Subject ID:</b> <input type="text"/>	<b>Reviewed by (certification no.):</b> <input type="text"/>	
<b>Visit:</b> <input type="text"/>	<b>For coordinator use only.</b>	<b>Review date:</b> <input type="text"/> / <input type="text"/> / <input type="text"/>	

### Teen-LABS (MED) Medications

**Form completion date:**  /  / 20 (mm/dd/yyyy)    **Form completed:**  In person     Over phone

Please PRINT NEATLY and complete this form in blue or black INK. Mark response boxes like this:

Most patients find it difficult to take all the medications and supplements recommended by their bariatric team. We are interested in knowing what supplements and vitamins you are currently taking and also what makes it difficult to take these. In order to make this easier, think about the supplements and vitamins you have taken in the **past week**.

For each supplement/ vitamin listed, please specify how many times a day your physician recommends that you take it **even if you are not taking it**. Next, specify if you are **currently** taking it, and if you are, how many times you think you have **messed** taking that supplement/ vitamin in the **past week**.

How many times a day ( <u>not</u> how many pills) does your physician <b>recommend</b> that you take the following supplements/vitamins? (If not at all, enter 0.)	Do you currently take this supplement/ vitamin?		If yes	How many times do you think you have <b>messed</b> taking your supplements/ vitamins in the past week?
	<u>No</u>	<u>Yes</u>		
1. A multivitamin (pill, chewable, liquid, or spray) <input type="text"/> times each day →	<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="text"/> times missed
2. Calcium (pill, chewable, liquid, or powder) <input type="text"/> times each day →	<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="text"/> times missed
3. Vitamin D alone (pill, chewable, liquid, or powder) <input type="text"/> times each day →	<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="text"/> times missed
4. Iron (pill, chewable, or liquid) <input type="text"/> times each day →	<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="text"/> times missed
5. Vitamin B12 (pill, liquid, or spray) <input type="text"/> times each day →	<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="text"/> times missed

6. Do you currently take Vitamin B-12 as an injection (shot)?  
 No     Yes    →    6.1 Did you miss your last shot?     No     Yes

7. How often does your physician recommend that you take Vitamin B-12 as an injection (shot)?  
 Does not recommend     Monthly     Other, specify: \_\_\_\_\_

8. What makes taking your supplements/vitamins difficult? Some patients have indicated the following reasons. Please mark all of the reasons that apply to you.
- |   |   |
|---|---|
| <input type="checkbox"/> Forgetting to take them or bring them with you         | <input type="checkbox"/> Hard to swallow  |
| <input type="checkbox"/> Inconvenient   | <input type="checkbox"/> Embarrassed to take them                                 |
| <input type="checkbox"/> Dosing schedules does not match my lifestyle           | <input type="checkbox"/> Difficult to understand doctor's instructions about them |
| <input type="checkbox"/> They don't work  | <input type="checkbox"/> Would rather do something else than take medications     |
| <input type="checkbox"/> Too expensive  | <input type="checkbox"/> I don't need them  |
| <input type="checkbox"/> Side effects (e.g. nausea, stomach ache, constipation) |   |

Site ID:

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### Teen-LABS (MED) Medications

9. Have you taken a multivitamin in the **past 90 days**?

No  Yes →

(Please bring your multi-vitamins to your next Teen LABS visit.)

9.1. What kind of multivitamin do you take (*mark only one*)?

- Adult  Child  
 Geriatric  Prenatal  
 Bariatric Specialty Blend  None of the above

9.2 Does your multivitamin contain minerals (*such as iron or calcium*)?

No  Yes  Don't know

10. In the **past week**, have you taken any pain medication, prescription or over-the-counter, for your back, hip(s), knees(s), or ankle(s)?  
*Mark "No" or "Yes" to each. If yes, also specify the number of days you took that medication in the past week.*

	No	Yes	If yes	Specify the number of days taken in the past week:
10.1 Your back	<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="text"/> days
10.2 Your hip(s)	<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="text"/> days
10.3 Your knee(s)	<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="text"/> days
10.4 Your ankle(s)	<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="text"/> days

11. In the **past week**, have you taken any prescription or over-the-counter medication for acid reflux, heartburn, or hiatal hernia?

No  Yes →

11.1 Specify the number of days you have taken medication in the last week for this:

days

12. In the **past week**, have you taken any low-dose aspirin (such as baby aspirin or one regular strength aspirin tablet) for reasons **other than for pain, such as to prevent heart attack or stroke**?

No  Yes →

12.1 Specify the number of days you have taken medication in the last week for this:

days



	Site ID: <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	Subject ID: <input style="width: 20px; height: 20px;" type="text"/>	Reviewed by (certification no.): <input style="width: 20px; height: 20px;" type="text"/>	
	Visit: <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	<b>For coordinator use only.</b>	Review date: <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	

### Teen-LABS (PSQ) Pediatric Sleep Questionnaire

**Form completion date:**  /  / 20 (mm/dd/yyyy)

Please PRINT NEATLY and complete this form in blue or black INK. Mark response boxes like this:

**Directions:** This form is to be filled out by a RESPONSIBLE ADULT living in the same household as the subject. The subject should NOT complete this form. Choose only ONE response for each item.

	<u>Yes</u>	<u>No</u>	<u>Don't know</u>
1. While sleeping, does your child...			
a. snore more than half the time?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. always snore?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. snore loudly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. have 'heavy' or loud breathing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. have trouble breathing or struggle to breathe?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever seen your child stop breathing during the night?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Does your child...			
a. tend to breathe through the mouth during the day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. have a dry mouth on waking up in the morning?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. occasionally wet the bed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. wake up feeling unrefreshed in the morning?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. have a problem with sleepiness during the day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Has a teacher or other supervisor commented that your child appears sleepy during the day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Is it hard to wake your child up in the morning?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Does your child wake up with headaches in the morning?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Did your child stop growing at a normal rate at any time since birth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. This child often...			
a. does not seem to listen when spoken to directly.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. has difficulty organizing task and activities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. is easily distracted by extraneous stimuli.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. fidgets with hands or feet or squirms in seat.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. is 'on the go' or often acts as if 'driven by a motor.'	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. interrupts or intrudes on others (e.g., butts into conversations or games).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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### Teen-LABS (WHQ) Weight History Questionnaire

**Form completion date:**  /  /  20  (mm/dd/yyyy)

Please PRINT NEATLY and complete this form in blue or black INK. Mark response boxes like this:

**Directions:** These questions are about your weight and size in the past. Your answers will be used to see if past weight impacts surgical results. Since you are recalling something from the past, next to your answer you should indicate how sure you are on a scale from 100% (completely sure) to 0% (not at all sure).

1. On your **13th birthday**, which happens when most people are in the 8th grade, how tall were you and how much did you weigh or, if you were pregnant, how much did you weigh before you were pregnant?

	Completely sure	CIRCLE										Not at all sure
Height at 13 years: <input type="text"/> ft <input type="text"/> in	How sure of answer:	100%	90	80	70	60	50	40	30	20	10	0%
Weight at 13 years: <input type="text"/> lbs	How sure of answer:	100%	90	80	70	60	50	40	30	20	10	0%

Compared to most other **13 year olds** would you say that you were:  
 Thinner than most     Heavier than most     About the same as most

2. On your **18th birthday**, which happens when most people are seniors in high school, how tall were you and how much did you weigh or, if you were pregnant, how much did you weigh before you were pregnant? (If you have not turned 18 years old yet, go to question 3.)

	Completely sure	CIRCLE										Not at all sure
Height at 18 years: <input type="text"/> ft <input type="text"/> in	How sure of answer:	100%	90	80	70	60	50	40	30	20	10	0%
Weight at 18 years: <input type="text"/> lbs	How sure of answer:	100%	90	80	70	60	50	40	30	20	10	0%

Compared to most other **18 year olds** would you say that you were (are):  
 Thinner than most     Heavier than most     About the same as most

3. At what **age** or **grade in school** did you first wear **any plus** size clothes or because of your weight, buy your clothes in a special section or store for larger people?

	Completely sure	CIRCLE										Not at all sure
1st wore plus: <input type="text"/> <b>age</b> <input type="text"/> <b>grade</b>	How sure of answer:	100%	90	80	70	60	50	40	30	20	10	0%
(circle which)												

4. Please estimate how many years of your life you have worn **only plus** size clothes:

	Completely sure	CIRCLE										Not at all sure
Number of years: <input type="text"/>	How sure of answer:	100%	90	80	70	60	50	40	30	20	10	0%

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### Teen-LABS (WHQ) Weight History Questionnaire

5. Since the first time you wore only plus size clothes, have you ever lost enough weight to wear **only regular** size clothes?

Yes    No   *(if no go to question 8)*

6. How many times would you say you have lost enough weight to wear **only regular** size clothes?

	Completely sure	CIRCLE										Not at all sure
Number of times: <input style="width: 40px;" type="text"/>	How sure of answer:	100%	90	80	70	60	50	40	30	20	10	0%

7. Since the age you first began wearing plus sized clothes, how many **total years** would you estimate you have maintained enough weight loss to wear **only regular** size clothes?

	Completely sure	CIRCLE										Not at all sure
Number of years: <input style="width: 40px;" type="text"/>	How sure of answer:	100%	90	80	70	60	50	40	30	20	10	0%

8. How many times **in your life** have you lost at least 50 pounds?

	Completely sure	CIRCLE										Not at all sure
Number of times: <input style="width: 40px;" type="text"/>	How sure of answer:	100%	90	80	70	60	50	40	30	20	10	0%

**Directions:** This next section is about the last year that you attended high school. If you are still in high school, answer the questions about the past twelve months. **DO NOT** include any limitations for reasons other than your weight.

**9. DURING MY FINAL YEAR OF HIGH SCHOOL OR DURING THE PAST TWELVE MONTHS, BECAUSE OF MY WEIGHT:**

	Never happened	Sometimes happened	Always happened	If <u>ever</u> happened, Age/Grade this <u>first</u> happened:
I had trouble fitting in a regular chair or desk	<input type="checkbox"/>	<input type="checkbox"/> ↳	<input type="checkbox"/> ↳	<input style="width: 40px;" type="text"/> age grade <i>(circle which)</i>
I was unable to walk up several flights of stairs	<input type="checkbox"/>	<input type="checkbox"/> ↳	<input type="checkbox"/> ↳	<input style="width: 40px;" type="text"/> age grade <i>(circle which)</i>
I could not participate in sports or other physically difficult activities	<input type="checkbox"/>	<input type="checkbox"/> ↳	<input type="checkbox"/> ↳	<input style="width: 40px;" type="text"/> age grade <i>(circle which)</i>
My clothes came from a special section or store for larger people	<input type="checkbox"/>	<input type="checkbox"/> ↳	<input type="checkbox"/> ↳	<input style="width: 40px;" type="text"/> age grade <i>(circle which)</i>

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## Teen-LABS (IPAQ) International Physical Activity Questionnaire

**Date form administered:**  /  /    (mm/dd/yyyy)

Please PRINT NEATLY and complete this form in blue or black INK. Mark response boxes like this:

We are interested in finding out about the kinds of physical activities that people do as part of their everyday lives. The questions will ask you about the time you spent being physically active in the **last 7 days**. Please answer each question even if you do not consider yourself to be an active person. Please think about the activities you do at work, as part of your house and yard work, to get from place to place, and in your spare time for recreation, exercise or sport.

Think about all the **vigorous** and **moderate** activities that you did in the **last 7 days**. **Vigorous** physical activities refer to activities that take hard physical effort and make you breathe much harder than normal. **Moderate** activities refer to activities that take moderate physical effort and make you breathe somewhat harder than normal.

### PART 1: JOB-RELATED PHYSICAL ACTIVITY

The first section is about your work. This includes paid jobs, farming, volunteer work, course work, and any other unpaid work that you did outside your home. Do not include unpaid work you might do around your home, like housework, yard work, general maintenance, and caring for your family. These are asked in Part 3.

1. Do you currently have a job or do any unpaid work outside of your home?

Yes

No → **IF NO, GO TO PART 2: TRANSPORTATION ON PAGE 2**

The next questions are about all the physical activity you did in the **last 7 days** as part of your paid or unpaid work. This does not include traveling to and from work.

2. During the **last 7 days**, on how many days did you do **vigorous** physical activities like heavy lifting, digging, heavy construction, or climbing up stairs **as part of your work**?

Think about only those physical activities that you did for at least 10 minutes at a time.

**days per week**

No vigorous job-related physical activity → **IF NO ACTIVITY, GO TO QUESTION 4**

3. How much time did you usually spend on one of those days doing **vigorous** physical activities as part of your work?

**hours per day**

**minutes per day**

4. Again, think about only those physical activities that you did for at least 10 minutes at a time. During the **last 7 days**, on how many days did you do **moderate** physical activities like carrying light loads **as part of your work**? Please do not include walking.

**days per week**

No moderate job-related physical activity → **IF NO ACTIVITY, GO TO QUESTION 6**

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### Teen-LABS (IPAQ) International Physical Activity Questionnaire

5. How much time did you usually spend on one of those days doing **moderate** physical activities as part of your work?

hours per day

minutes per day

6. During the **last 7 days**, on how many days did you **walk** for at least 10 minutes at a time **as part of your work**?  
Please do not count any walking you did to travel to or from work.

days per week

No job-related walking → **IF NO WALKING, GO TO PART 2: TRANSPORTATION**

7. How much time did you usually spend on one of those days **walking** as part of your work?

hours per day

minutes per day

#### PART 2: TRANSPORTATION PHYSICAL ACTIVITY

These question are about how you traveled from place to place, including to places like work, stores, movies, and so on.

8. During the **last 7 days**, on how many days did you **travel in a motor vehicle** like train, bus, car, or tram?

days per week

No traveling in a motor vehicle → **IF NO TRAVEL, GO TO QUESTION 10**

9. How much time did you usually spend on one of those days **traveling** in a train, bus, car, tram, or other kind of motor vehicle?

hours per day

minutes per day

Now think only about the **bicycling** and **walking** you might have done to travel to and from work, to do errands, or to go from place to place.

10. During the **last 7 days**, on how many days did you **bicycle** for at least 10 minutes at a time to go **from place to place**?

days per week

No bicycling from place to place → **IF NO BICYCLING, GO TO QUESTION 12**

11. How much time did you usually spend on one of those days to **bicycle** from place to place?

hours per day

minutes per day

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### Teen-LABS (IPAQ) International Physical Activity Questionnaire

12. During the **last 7 days**, on how many days did you **walk** for at least 10 minutes at a time to go **from place to place**?

**days per week**

No walking from place to place → ***IF NO WALKING, GO TO PART 3: HOUSEWORK, HOUSE MAINTENANCE, AND CARING FOR FAMILY***

13. How much time did you usually spend on one of those days to **walk** from place to place?

**hours per day**

**minutes per day**

#### ***PART 3: HOUSEWORK, HOUSE MAINTENANCE, AND CARING FOR FAMILY***

This section is about some of the physical activities you might have done in the **last 7 days** in and around your home, like housework, gardening, yard work, general maintenance work, and caring for your family.

14. Think about only those physical activities that you did for at least 10 minutes at a time. During the **last 7 days**, on how many days did you do **vigorous** physical activities like heavy lifting, chopping wood, shoveling snow, or digging **in the garden or yard**?

**days per week**

No vigorous activity in garden or yard → ***IF NO ACTIVITY, GO TO QUESTION 16***

15. How much time did you usually spend on one of those days doing **vigorous** physical activities in the garden or yard?

**hours per day**

**minutes per day**

16. Again, think about only those physical activities that you did for at least 10 minutes at a time. During the **last 7 days**, on how many days did you do **moderate** activities like carrying light loads, sweeping, washing windows, and raking **in the garden or yard**?

**days per week**

No moderate activity in garden or yard → ***IF NO ACTIVITY, GO TO QUESTION 18***

17. How much time did you usually spend on one of those days doing **moderate** physical activities in the garden or yard?

**hours per day**

**minutes per day**

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### Teen-LABS (IPAQ) International Physical Activity Questionnaire

18. Once again, think about only those physical activities that you did for at least 10 minutes at a time. During the **last 7 days**, on how many days did you do **moderate** activities like carrying light loads, washing windows, scrubbing floors and sweeping **inside your home**?

**days per week**

No moderate activity inside home → ***IF NO WALKING, GO TO PART 4: RECREATION, SPORT, AND LEISURE-TIME PHYSICAL ACTIVITY***

19. How much time did you usually spend on one of those days doing **moderate** physical activities inside your home?

**hours per day**

**minutes per day**

#### ***PART 4: RECREATION, SPORT, AND LEISURE-TIME PHYSICAL ACTIVITY***

This section is about some of the physical activities that you did in the **last 7 days** solely for recreation, sport, exercise or leisure. Please do not include any activities you have already mentioned.

20. Not counting any walking you have already mentioned, during the **last 7 days**, on how many days did you **walk** for at least 10 minutes at a time **in your leisure time**?

**days per week**

No walking in leisure time → ***IF NO WALKING, GO TO QUESTION 22***

21. How much time did you usually spend on one of those days **walking** in your leisure time?

**hours per day**

**minutes per day**

22. Think about only those physical activities that you did for at least 10 minutes at a time. During the **last 7 days**, on how many days did you do **vigorous** physical activities like aerobics, running, fast bicycling, or fast swimming **in your leisure time**?

**days per week**

No vigorous activity in leisure time → ***IF NO ACTIVITY, GO TO QUESTION 24***

23. How much time did you usually spend on one of those days doing **vigorous** physical activities in your leisure time?

**hours per day**

**minutes per day**

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### Teen-LABS (IPAQ) International Physical Activity Questionnaire

24. Again, think about only those physical activities that you did for at least 10 minutes at a time. During the **last 7 days**, on how many days did you do **moderate** physical activities like bicycling at a regular pace, swimming at a regular pace, and doubles tennis **in your leisure time**?

**days per week**

No moderate activity in leisure time → ***IF NO ACTIVITY, GO TO PART 5: TIME SPENT SITTING***

25. How much time did you usually spend on one of those days doing **moderate** physical activities in your leisure time?

**hours per day**

**minutes per day**

#### ***PART 5: TIME SPENT SITTING***

The last questions are about the time you spend sitting while at work, at home, while doing course work and during leisure time. This may include time spent sitting at a desk, visiting friends, reading or sitting or lying down to watch television. Do not include any time spent sitting in a motor vehicle that you have already told me about.

26. During the **last 7 days**, how much time did you usually spend **sitting** on a **weekday**?

**hours per day**

**minutes per day**

27. During the **last 7 days**, how much time did you usually spend **sitting** on a **weekend day**?

**hours per day**

**minutes per day**

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### Teen-LABS (IPS) International Prevalence Study on Physical Activity

**Date form administered:**  /  / 20 (mm/dd/yyyy)

Please PRINT NEATLY and complete this form in blue or black INK. Mark response boxes like this:

Think about the different facilities in and around your neighborhood by this we mean the area ALL around your home that you could walk to in **10-15 minutes**.

1. What is the main type of housing in your neighborhood?

- Detached single-family housing
- Townhouses, row houses, apartments, or condos of 2-3 stories
- Mix of single-family residences and townhouses, row houses, apartments or condos
- Apartments or condos of 4-12 stories
- Apartments or condos of more than 12 stories
- Don't know/Not sure

The next items are statements about your neighborhood related to walking and bicycling.

2. Many shops, stores, markets or other places to buy things I need are within easy walking distance of my home. Would you say that you...

- Strongly disagree
- Somewhat disagree
- Somewhat agree
- Strongly agree
- Don't know/Not sure

3. It is within a 10-15 minutes walk to a transit stop (such as a bus, train, trolley, or tram) from my home. Would you say that you...

- Strongly disagree
- Somewhat disagree
- Somewhat agree
- Strongly agree
- Don't know/Not sure

4. There are sidewalks on most of the streets in my neighborhood. Would you say that you...

- Strongly disagree
- Somewhat disagree
- Somewhat agree
- Strongly agree
- Does not apply to my neighborhood
- Don't know/Not sure

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### Teen-LABS (IPS) International Prevalence Study on Physical Activity

5. There are facilities to bicycle in or near my neighborhood, such as special lanes, separate paths or trails, shared use paths for cycles and pedestrians. Would you say that you...
- Strongly disagree
  - Somewhat disagree
  - Somewhat agree
  - Strongly agree
  - Does not apply to my neighborhood
  - Don't know/Not sure
6. My neighborhood has several **free** or **low cost** recreation facilities, such as parks, walking trails, bike paths, recreation centers, playgrounds, public swimming pools, etc. Would you say that you...
- Strongly disagree
  - Somewhat disagree
  - Somewhat agree
  - Strongly agree
  - Don't know/Not sure
7. The crime rate in my neighborhood makes it unsafe to go on walks at night. Would you say that you...
- Strongly disagree
  - Somewhat disagree
  - Somewhat agree
  - Strongly agree
  - Don't know/Not sure
8. There is so much traffic on the streets that it makes it difficult or unpleasant to walk in my neighborhood. Would you say that you...
- Strongly disagree
  - Somewhat disagree
  - Somewhat agree
  - Strongly agree
  - There are no streets or roads in my neighborhood
  - Don't know/Not sure
9. I see many people being physically active in my neighborhood doing things like walking, jogging, cycling, or playing sports and active games. Would you say that you...
- Strongly disagree
  - Somewhat disagree
  - Somewhat agree
  - Strongly agree
  - Don't know/Not sure

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### Teen-LABS (IPS) International Prevalence Study on Physical Activity

10. There are many interesting things to look at while walking in my neighborhood. Would you say that you...

- Strongly disagree
- Somewhat disagree
- Somewhat agree
- Strongly agree
- Don't know/Not sure

11. How many motor vehicles in working order (e.g., cars, trucks, motorcycles) are there at your household?

motor vehicles in working order

- Don't know/Not sure

12. There are many four-way intersections in my neighborhood. Would you say that you...

- Strongly disagree
- Somewhat disagree
- Somewhat agree
- Strongly agree
- There are no streets or roads in my neighborhood
- Don't know/Not sure

13. The sidewalks in my neighborhood are well maintained (paved, with few cracks) and not obstructed. Would you say that you...

- Strongly disagree
- Somewhat disagree
- Somewhat agree
- Strongly agree
- Don't know/Not sure

14. Places for bicycling (such as bike paths) in and around my neighborhood are well maintained and not obstructed. Would you say that you...

- Strongly disagree
- Somewhat disagree
- Somewhat agree
- Strongly agree
- Don't know/Not sure

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### Teen-LABS (IPS) International Prevalence Study on Physical Activity

15. There is so much traffic on the streets that it makes it difficult or unpleasant to ride a bicycle in my neighborhood.

Would you say that you...

- Strongly disagree
- Somewhat disagree
- Somewhat agree
- Strongly agree
- Don't know/Not sure

16. The crime rate in my neighborhood makes it unsafe to go on walks during the day. Would you say that you...

- Strongly disagree
- Somewhat disagree
- Somewhat agree
- Strongly agree
- Don't know/Not sure

17. There are many places to go within easy walking distance of my home. Would you say that you...

- Strongly disagree
- Somewhat disagree
- Somewhat agree
- Strongly agree
- Don't know/Not sure