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 ↓

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*

☐ Yes ↓

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

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

For coordinator use only. 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)	☐	☐	___	___ / ___ / ___
Biliopancreatic div. (BPD)	☐	☐	___	___ / ___ / ___
Biliopancreatic div. w/switch (BPDS)	☐	☐	___	___ / ___ / ___
Adjustable Gastric Band (AGB)	☐	☐	___	___ / ___ / ___
Vertical Banded Gast. (VBG)	☐	☐	___	___ / ___ / ___
Sleeve Gastrectomy (SG)	☐	☐	___	___ / ___ / ___
Prior surgery performed on the esophagus, stomach, or proximal small intestine NOT for the purpose of weight loss	☐	☐	___	___ / ___ / ___
Other previous obesity surgery 1 *Specify:* _____	☐	☐	___	___ / ___ / ___
Other previous obesity surgery 2 *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: ☐☐☐☐☐

For coordinator use only.

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.)*

No	Yes	
☐	☐	Therapeutic oral/IV immunosuppressant
☐	☐	Therapeutic anticoagulation
☐	☐	Narcotic
☐	☐	Statin or other lipid lowering agent
☐	☐	Antidepressant
☐	☐	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

Site ID: ☐☐☐ Subject ID: ☐☐☐☐☐

For coordinator use only.

Teen-LABS (PO) Pre-Operative Form

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

Comorbidity	No	Yes		If yes, mark the one best response
a. Hypertension	☐	☐	→	☐ No medication ☐ Single medication ☐ Multiple medications
b. Diabetes	☐	☐	→	☐ No medication ☐ Single oral medication ☐ Multiple oral medications ☐ Insulin ☐ Oral meds and insulin
c. CHF	☐	☐	→	NYHC: ☐ I ☐ II ☐ III ☐ IV ☐ Unknown
d. Asthma	☐	☐	→	☐ History of Intubation ☐ No History of Intubation

Comorbidity	No	Yes		If yes, mark "No" or "Yes" for each item		
				No	Yes	
e. History of DVT/PE	☐	☐	→	☐	☐	Documented DVT
				☐	☐	Documented PE
				☐	☐	Venous edema w/ulceration
f. Sleep apnea	☐	☐	→	☐	☐	C-pap/Bi-pap
				☐	☐	Supplemental oxygen dependent
g. Ischemic Heart Disease	☐	☐	→	☐	☐	History of MI
				☐	☐	No active ischemia
				☐	☐	Abnormal EKG but unable to assess ischemia
				☐	☐	PCI, CABG
				☐	☐	Anti-ischemic medications

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

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.)*

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

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

Teen-LABS (ANTH) Anthropometrics

Evaluation date: ☐☐ / ☐☐ / 20☐☐ *(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
Height:	☐☐☐.☐☐ cm	☐☐☐.☐☐ cm	☐☐☐.☐☐ cm	☐ Height
Measured:	☐ Standing ☐ Lying flat* ☐ Estimate*	☐ Standing ☐ Lying flat* ☐ Estimate*	☐ Standing ☐ Lying flat* ☐ Estimate*	

*Specify why height wasn't measured standing:

Weight:	☐☐☐.☐☐ kg	☐☐☐.☐☐ kg	☐☐☐.☐☐ kg	☐ Weight
Percent body fat:	☐☐.☐☐ %	☐☐.☐☐ %	☐☐.☐☐ %	
Impedance:	☐☐☐ Ω	☐☐☐ Ω	☐☐☐ Ω	
Weight measured:	☐ Tanita Scale ☐ Other Scale* ☐ Last available bed weight* ☐ Estimate*	☐ Tanita Scale ☐ Other Scale* ☐ Last available bed weight* ☐ Estimate*	☐ Tanita Scale ☐ Other Scale* ☐ Last available bed weight* ☐ Estimate*	

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

Midpoint waist circumference:	☐☐☐.☐☐ cm	☐☐☐.☐☐ cm	☐☐☐.☐☐ cm	☐ Umbilical
Iliac waist circumference:	☐☐☐.☐☐ cm	☐☐☐.☐☐ cm	☐☐☐.☐☐ cm	☐ Iliac
Sagittal abdominal diameter:	☐☐☐.☐☐ cm	☐☐☐.☐☐ cm	☐☐☐.☐☐ cm	☐ Sagittal
Neck circumference:	☐☐☐.☐☐ cm	☐☐☐.☐☐ cm	☐☐☐.☐☐ cm	☐ Neck
Resting heart rate:	☐☐☐ bpm	☐☐☐ bpm	☐☐☐ bpm	☐ Heart rate
Blood pressure: (systolic/diastolic)	☐☐☐ / ☐☐☐	☐☐☐ / ☐☐☐	☐☐☐ / ☐☐☐	☐ BP
Measured:	☐ Mercury ☐ Gauge ☐ Electronic	☐ Mercury ☐ Gauge ☐ Electronic	☐ Mercury ☐ Gauge ☐ 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^2 → Value in relation to reference range: ☐ High ☐ Within ☐ Low

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

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

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.

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

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

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

Teen-LABS (MWE) 400 Meter Walk Eligibility 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. Does the patient use a wheel chair, walker, or quad cane? ☐ No ☐ Yes → ***If yes, do not test.***

2. Blood pressure: ☐☐☐ / ☐☐☐ (mmHg)*
   (systolic) *(diastolic)*

   2.1 Is SBP more than 180 mmHg? ☐ No ☐ Yes → ***If yes, do not test.***

   2.2 Is DBP more than 100 mmHg? ☐ No ☐ Yes → ***If yes, do not test.***

3. Resting heart rate: ☐☐☐ (bpm)*

   3.1 Is resting heart rate more than 130 bpm? ☐ No ☐ Yes → ***If yes, do not test.***

   3.2 Is resting heart rate less than 40 bpm? ☐ No ☐ Yes → ***If yes, do not test.***

4. Is there evidence of any of the following abnormal ECG findings in the **past 12 months**? *Mark "Yes" or "No" for each.*

No	Yes	
☐	☐	Atrial fibrillation or atrial flutter (new onset)
☐	☐	Wolff-Parkinson-White (WPW) or ventricular pre-excitation
☐	☐	Idioventricular rhythm
☐	☐	Ventricular tachycardia
☐	☐	Third degree or complete A-V block
☐	☐	Any statement including reference to acute injury or acute ischemia, or marked T-wave abnormality
☐	☐	Abnormal cardiogram indicative of ischemia without medical/cardiac clearance for surgery, specify:

↓ _____

If any are yes, do not test.

5. In the **past 3 months**: *(Mark "Yes" or "No" for each.)*

No	Yes	
☐	☐	Were you hospitalized for myocardial infarction or heart attack?
☐	☐	Have you had angioplasty or heart surgery?
☐	☐	Have you seen a health care professional or thought about seeing a health care professional for new or worsening symptoms of chest pain?
☐	☐	Have you had angina?
☐	☐	Did you have major thoracic (chest), abdominal, or joint surgery?
☐	☐	Were you hospitalized for 3 or more days?

↳ ***If any are yes, do not test until screened and approved by PI or Co-investigator at site and complete Off Protocol Form (TL_OFF) with rationale if walk is attempted/completed.***

If participant has not already been disqualified ask:

6. Do you feel it would be **UNSAFE** for you to walk up and down this hallway? ☐ No ☐ Yes → ***If yes, do not test.***

   6.1 If yes, specify: _____

7. Are you wearing shoes that make it difficult for you to walk? ☐ No ☐ Yes → ***If yes, do not test.***
   If patient has comfortable shoes to change into, ask participant to change shoes and mark no.

*If physical measures are done within 24 hours of completing this form, then the blood pressure (item 2) and resting pulse (item 3) can be transcribed from the Anthropometrics form.

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

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

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 no 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.

	1		**2**		**3**		**4***		**5**		**6**		**7**		**8***		**9**		**10**

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	☐	☐	☐	☐	☐
2	☐	☐	☐	☐	☐
3	☐	☐	☐	☐	☐
4	☐	☐	☐	☐	☐
5	☐	☐	☐	☐	☐
6	☐	☐	☐	☐	☐
7	☐	☐	☐	☐	☐
8	☐	☐	☐	☐	☐
9	☐	☐	☐	☐	☐
10	☐	☐	☐	☐	☐

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		No	Yes	
☐	☐	Participant reported that they felt too tired	☐	☐	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: ☐☐ **For coordinator use only.**

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:

	No	Yes	Don't know	Refused
12.1 Chest pain?	☐	☐	☐	☐
12.2 Shortness of breath?	☐	☐	☐	☐
12.3 Knee pain?	☐	☐	☐	☐
12.4 Hip pain?	☐	☐	☐	☐
12.5 Calf pain?	☐	☐	☐	☐
12.6 Foot pain?	☐	☐	☐	☐
12.7 Numbness or tingling in your legs or feet?	☐	☐	☐	☐
12.8 Leg cramps?	☐	☐	☐	☐
12.9 Back pain?	☐	☐	☐	☐
12.10 Other *specify:*	☐	☐	☐	☐

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.

	No	Yes
13.1 Chest pain, pressure	☐	☐
13.2 Shortness of breath	☐	☐
13.3 Loss of consciousness or an acute or new-onset bout of 'dizziness' and/or 'lightheadedness'	☐	☐
13.4 Persistent severe lower extremeity pain that does not resolve	☐	☐
13.5 Wheezing or dyspnea	☐	☐
13.6 Other *specify:*	☐	☐

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

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

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	☐	☐	☐	→	☐ Normal ☐ Abnormal
1.2 Stress test: ☐ Exercise ☐ Chemical	☐	☐	☐	→	☐ Normal ☐ Abnormal
1.3 Right Heart Catherization	☐	☐	☐	→	☐ Normal ☐ Abnormal
1.4 Left Heart Catherization	☐	☐	☐	→	☐ Normal ☐ Abnormal
1.5 Cardiac function (Based on an echocardiogram, cardiac MRI, CT imaging, ventriculography, Gated SPECT, MUGA.)	☐	☐	☐	→	LVEF: ☐☐☐.☐☐ % *enter "-3" if no percent available* If no percent available: ☐ Normal ☐ Abnormal LVMI: ☐☐☐.☐☐ $g/m^{2.7}$ LV mass: ☐☐☐.☐☐ gm Relative wall thickness: ☐☐.☐☐
1.6 Endoscopy	☐	☐	☐	→	H. pylori: ☐ No ☐ Yes ☐ Not done Barret's Esophagus: ☐ No ☐ Yes Hiatal Hernia: ☐ No ☐ Yes
1.7 Upper GI series	☐	☐	☐	→	Paraesophageal Hernia: ☐ No ☐ Yes Hiatal Hernia: ☐ No ☐ Yes
1.8 Pulseoximeter	☐	☐	☐	→	SAO_2: ☐☐☐.☐☐ %
1.9 ECG	☐	☐	☐	→	No Yes ☐ ☐ Normal ☐ ☐ Atrial Fib. ☐ ☐ Sinus Tach. ☐ ☐ Other Arrhythmia No Yes ☐ ☐ ST-T waves indicating possible ischemia ☐ ☐ Other, specify: ____
1.10 Polysomnogram	☐	☐	☐	→	Apnea-Hypopnea Index (AHI): ☐☐☐.☐
1.11 Pulmonary Function Test (PFT)	☐	☐	☐	→	FEV1: ☐☐.☐☐ L % of defusing capacity: ☐☐☐.☐☐ FVC: ☐☐.☐☐ L
1.12 Arterial blood gas	☐	☐	☐	→	CO_2: ☐☐ (mmHg) O_2 on room air temp: ☐☐☐.☐☐ (mmHg) O_2 on oxygen: ☐☐☐.☐☐ (mmHg)
1.13 Ultrasound gall bladder	☐	☐	☐	→	Evidence of gallstones: ☐ No ☐ Yes
1.14 Other: ____	☐	☐	☐	→	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

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

Teen-LABS (RCAF) Research Coordinator 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 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.)*

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

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

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: ☒

BLOOD SAMPLES	BLOOD DRAW DATE *(MM/DD/YY)*	LAB VALUE	VALUE IN RELATION TO REFERENCE RANGE: HIGH	WITHIN	LOW	NOT DONE
Albumin:	☐☐ / ☐☐ / ☐☐	☐☐.☐ g/dl	☐	☐	☐	☐
AST(SGOT):	☐☐ / ☐☐ / ☐☐	☐☐☐ IU/L	☐	☐	☐	☐
ALT (SGPT):	☐☐ / ☐☐ / ☐☐	☐☐☐ IU/L	☐	☐	☐	☐
Alkaline Phosphatase:	☐☐ / ☐☐ / ☐☐	☐☐☐ IU/L	☐	☐	☐	☐
Platelet:	☐☐ / ☐☐ / ☐☐	☐☐☐.☐☐ $10^3/mm^3$	☐	☐	☐	☐
Total Cholesterol:	☐☐ / ☐☐ / ☐☐	☐☐☐ mg/dl	☐	☐	☐	☐
HDL:	☐☐ / ☐☐ / ☐☐	☐☐☐ mg/dl	☐	☐	☐	☐
LDL:	☐☐ / ☐☐ / ☐☐	☐☐☐ mg/dl	☐	☐	☐	☐
Triglycerides:	☐☐ / ☐☐ / ☐☐	☐☐☐ mg/dl	☐	☐	☐	☐
CRP:	☐☐ / ☐☐ / ☐☐	☐☐.☐ µM	☐	☐	☐	☐
OGTT glucose baseline:	☐☐ / ☐☐ / ☐☐	☐☐☐ mg/dl	☐	☐	☐	☐
OGTT glucose 1 hour:	☐☐ / ☐☐ / ☐☐	☐☐☐ mg/dl	☐	☐	☐	☐
OGTT glucose 2 hours:	☐☐ / ☐☐ / ☐☐	☐☐☐ mg/dl	☐	☐	☐	☐
Fasting Insulin:	☐☐ / ☐☐ / ☐☐	☐☐☐.☐ µU/ml	☐	☐	☐	☐
HbA1C:	☐☐ / ☐☐ / ☐☐	☐☐.☐ %	☐	☐	☐	☐
Normal HbA1C **high** range:	☐☐.☐ %					

Site ID: ☐☐☐ Subject ID: ☐☐☐☐☐

Visit: ☐☐ **For coordinator use only.**

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

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

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

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

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	
☐	☐	Therapeutic oral/IV immunosuppressant
☐	☐	Therapeutic anticoagulation
☐	☐	Narcotic
☐	☐	Statin or other lipid lowering agent
☐	☐	Antidepressant
☐	☐	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 one best response
a. Hypertension	☐	☐	→	☐ No medication ☐ Single medication ☐ Multiple medications
b. Diabetes	☐	☐	→	☐ No medication ☐ Single oral medication ☐ Multiple oral medications ☐ Insulin ☐ Oral meds and insulin
c. CHF	☐	☐	→	NYHC: ☐ I ☐ II ☐ III ☐ IV ☐ Unknown
d. Asthma	☐	☐	→	☐ History of Intubation ☐ No History of Intubation

Comorbidity	No	Yes		If yes, mark "No" or "Yes" for each item	
				No	Yes
e. History of DVT/PE	☐	☐	→	☐	☐ Documented DVT
				☐	☐ Documented PE
				☐	☐ Venous edema w/ulceration
f. Sleep apnea	☐	☐	→	☐	☐ C-pap/Bi-pap
				☐	☐ Supplemental oxygen dependent
g. Ischemic Heart Disease	☐	☐	→	☐	☐ History of MI
				☐	☐ No active ischemia
				☐	☐ Abnormal EKG but unable to assess ischemia
				☐	☐ PCI, CABG
				☐	☐ Anti-ischemic medications

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

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

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

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.)*

No	Yes		No	Yes	
☐	☐	Support hose	☐	☐	Elevation of the legs
☐	☐	Diuretic	☐	☐	Unna boots
☐	☐	Blood thinners	☐	☐	Sequential compression boots
			☐	☐	Other *specify:* _____

4.2 PE confined to:

☐ Pedal/ankle ☐ Mid calf ☐ High calf

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 >=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

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: ☐ with fibrosis ☐ 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)

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: ☐☐☐☐☐

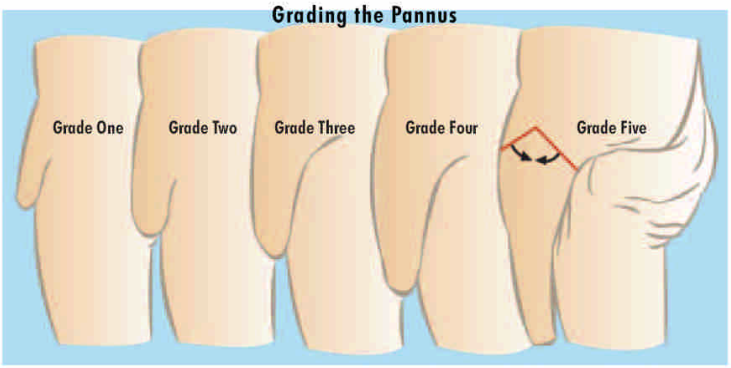
For coordinator use only.

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	
☐	☐	Intertiginous/fungal cutaneous infection
☐	☐	Recurrent cellulitis
☐	☐	Superficial cutaneous ulceration
☐	☐	Deep ulceration/persistent drainage
☐	☐	Necrotizing fasciitis or surgical treatment required
☐	☐	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: ☐☐☐ Subject ID: ☐☐☐☐☐ Reviewed by (certification no.): ☐☐☐☐

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

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 <u>current status</u> 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 <u>current</u> 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.)*

No	Yes		No	Yes	
☐	☐	Support hose	☐	☐	Elevation of the legs
☐	☐	Diuretic	☐	☐	Unna boots
☐	☐	Blood thinners	☐	☐	Sequential compression boots
			☐	☐	Other *specify:* _____

4.2 PE confined to:

☐ Pedal/ankle ☐ Mid calf ☐ High calf

Teen-LABS (CAF) Comorbidity Assessment Follow-up

Characterize the patient's <u>current</u> 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 <u>two weeks</u>. 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 >=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

Teen-LABS (CAF) Comorbidity Assessment Follow-up

Characterize the patient's <u>current</u> 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 **<u>since last study visit</u>**?
   - ☐ No
   - ☐ Yes

10. GERD:
   a. Has there been any formal diagnostic testing for GERD **<u>since last study visit</u>**?
   - ☐ No
   - ☐ Yes → 10a.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

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

Teen-LABS (CAF) Comorbidity Assessment Follow-up

Characterize the patient's <u>current</u> 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: ☐ with fibrosis ☐ 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)

Teen-LABS (CAF) Comorbidity Assessment Follow-up

Characterize the patient's <u>current</u> 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

Site ID: ☐☐☐ Subject ID: ☐☐☐☐☐

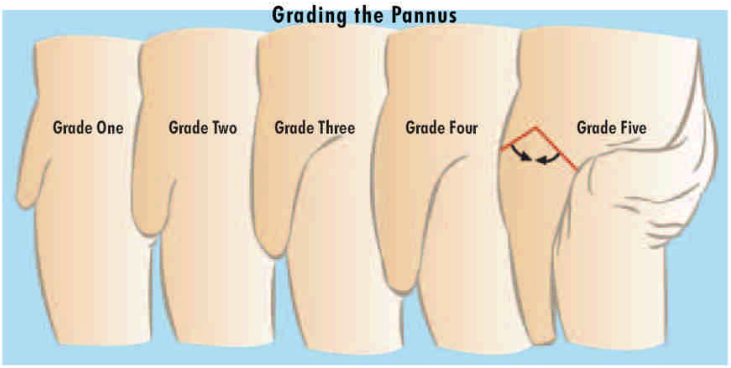
Visit: ☐☐ **For coordinator use only.**

Teen-LABS (CAF) Comorbidity Assessment Follow-up

Characterize the patient's <u>current</u> 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 →

Mark "No" or "Yes" to each.

No	Yes	
☐	☐	Intertiginous/fungal cutaneous infection
☐	☐	Recurrent cellulitis
☐	☐	Superficial cutaneous ulceration
☐	☐	Deep ulceration/persistent drainage
☐	☐	Necrotizing fasciitis or surgical treatment required
☐	☐	Lymphedema of the pannus

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

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

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

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.)*	
☐	☐	Support hose	☐ ☐ Elevation of the legs
☐	☐	Diuretic	☐ ☐ Unna boots
☐	☐	Operation(s)	☐ ☐ Sequential compression boots
☐	☐	Blood thinners	☐ ☐ Other *specify:* _____
☐	☐	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.)*
☐	☐	Sensory	☐ ☐ Speech problems
☐	☐	Motor	☐ ☐ 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 cerbri (PTC)	*If yes* → 17.1 Undergone surgery for PTC? ☐ No ☐ Yes
☐	☐	18. Coagulopathy	
☐	☐	19. History of ventral hernia	

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

No	Yes		No	Yes	
☐	☐	Asymptomatic hernia, no prior operation	☐	☐	Chronic evisceration through large hernia with associated complication or multiple failed hernia repairs
☐	☐	Symptomatic or incarcerated hernia			
☐	☐	Successful repair			
		↳ *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.)*

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

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

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.): ☐☐☐☐

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

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.)*

No	Yes		No	Yes	
☐	☐	Support hose	☐	☐	Elevation of the legs
☐	☐	Diuretic	☐	☐	Unna boots
☐	☐	Operation(s)	☐	☐	Sequential compression boots
☐	☐	Blood thinners	☐	☐	Other *specify:* _____

☐ ☐ 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.)*

No	Yes		No	Yes	
☐	☐	Sensory	☐	☐	Speech problems
☐	☐	Motor	☐	☐	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 cerbri (PTC)	*If yes* → 17.1 Undergone surgery for PTC? ☐ No ☐ Yes
☐	☐	18. Coagulopathy	
☐	☐	19. Ventral hernia	

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

No	Yes		No	Yes	
☐	☐	Asymptomatic hernia, no prior operation	☐	☐	Chronic evisceration through large hernia with associated complication or multiple failed hernia repairs
☐	☐	Symptomatic or incarcerated hernia			
☐	☐	Successful repair	☐	☐	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.

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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.

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Class I: Symptoms with more than ordinary activity; no limitations. Ordinary physical activity does not cause undue fatigue, dyspnea, or palpitations.

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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.

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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: ___ / ___ / 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. POUCH STAPLING MEASUREMENTS:

	How was it measured? String	Ruler	Grasper	Visually	Not done
1.1 Total length of staple line: ____.____ cm →	☐	☐	☐	☐	☐

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)*:

No	Yes		No	Yes	
☐	☐	2.5 millimeters	☐	☐	4.5 millimeters
☐	☐	3.5 millimeters	☐	☐	Other, specify: ____.____ 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: ____.____ cm →	☐	☐	☐	☐	☐
7.2 Length of the alimentary limb: ____.____ cm →	☐	☐	☐	☐	☐
7.3 Length of the common channel: ____.____ cm →	☐	☐	☐	☐	☐

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:	☐ No	☐ Yes →	☐ Neg	☐ Pos			1. Suture repair:	☐ No	☐ Yes
2. Air by endoscopy:	☐ No	☐ Yes →	☐ Neg	☐ Pos	☐ No	☐ Yes →	2. Glue:	☐ No	☐ Yes
3. Methylene Blue:	☐ No	☐ Yes →	☐ Neg	☐ Pos			3. Complete anastomosis redo:	☐ No	☐ 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 ☐ Yes

13. Record the configuration used for the distal (Jejunum-Jejunum) anastomosis: ☐ Side-to-side ☐ End-to-side

Site ID: ☐☐☐ Subject ID: ☐☐☐☐☐

For coordinator use only.

Teen-LABS (RYB) Roux-en-Y Gastric Bypass

14. Method of distal (Jejunum-Jejunum) anastomosis *(mark "No" or "Yes" for each)*:

No	Yes		
☐	☐	Hand sewn	→ 14.1 Stitch type: ☐ Absorbable ☐ Non-absorbable 14.2 Stitch layers: ☐ One layer ☐ Two layers
☐	☐	Linear stapled	→ 14.3 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 14.4 Staple manufacturer: ☐ U.S. Surgical ® ☐ Ethicon ® ☐ Other, specify: _____
☐	☐	Circular stapled	→ 14.5 Diameter of stapler: ☐ 21 mm ☐ 25 mm ☐ Other, specify: ___.___ mm 14.6 Staple manufacturer: ☐ U.S. Surgical ® ☐ Ethicon ® ☐ Other, specify: _____ 14.7 Pre-closure height of staples (mark all that apply): ☐ 2.5 mm ☐ 3.5 mm ☐ 4.5 mm ☐ 4.8 mm ☐ Other, specify: ___.___ mm 14.8 Length of Jejunum-jejunal anastomosis: ___.__ cm

15. Mesenteric defects closure *(mark "No" or "Yes" for each)*:

No	Yes	
☐	☐	Petersen's
☐	☐	Entero-enterostomy
☐	☐	Transmesenteric -- *Only answer if route of alimentary limb ascension (question 6) was retro-colic.*

16. Was an anti-obstruction stitch placed? ☐ No ☐ Yes

17. Were the laterjet nerves seen? ☐ No ☐ Yes

18. Were the laterjet nerves cut? ☐ No ☐ Yes → 18.1 Specify: ☐ Partially cut ☐ Completely cut

19. 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 — Very difficult

1 2 3 4 5 6 7 8 9 10

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

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

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

23. 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 (GS) Gastric Sleeve

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. SLEEVE STAPLING MEASUREMENTS:

		How was it measured? String	Ruler	Grasper	Visually	Not done
1.1 Total length of staple line:	☐☐.☐☐ cm →	☐	☐	☐	☐	☐
1.2 Bougie/tube size:	☐☐ Fr	*(N/A)*				
1.3 Distance from the Pylorus to the sleeve staple line:	☐☐.☐☐ cm →	☐	☐	☐	☐	☐

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:	☐ No	☐ Yes →	☐ Neg	☐ Pos				1. Suture repair:	☐ No	☐ Yes
2. Air by endoscopy:	☐ No	☐ Yes →	☐ Neg	☐ Pos	☐ No	☐ Yes →		2. Glue:	☐ No	☐ Yes
3. Methylene Blue:	☐ No	☐ Yes →	☐ Neg	☐ Pos				3. Complete anastomosis redo:	☐ No	☐ Yes

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									Very difficult
1	2	3	4	5	6	7	8	9	10

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
   - ☐ 10 cm
   - ☐ 11 cm (or Vanguard ®)
   - ☐ AP™ Small
   - ☐ AP™ Large
   - ☐ 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? ☐ No ☐ Yes → # of bites: ___
   - 4.2 Were they interrupted sutures? ☐ No ☐ Yes → # of sutures: ___

   ☐ 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)*:

No	Yes	
☐	☐	Pars Flaccida
☐	☐	Perigastric
☐	☐	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: ☐ Partially cut ☐ Completely cut

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									Very difficult
1	2	3	4	5	6	7	8	9	10

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: ___ / ___ / 20___ *(mm/dd/yyyy)* **Completed by (certification no.):** _____

Date of Surgery: ___ / ___ / 20___ **Date of adjustment:** ___ / ___ / 20___

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)*:

No	Yes		No	Yes	
☐	☐	Routine	☐	☐	Esophageal Dilatation
☐	☐	Weight gain	☐	☐	Solid food intolerance
☐	☐	Lack of weight loss	☐	☐	Reflux symptoms
☐	☐	Reduced early satiety	☐	☐	Pregnancy
☐	☐	Nausea/vomiting	☐	☐	Other *specify:* _____
☐	☐	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)*:

No	Yes		No	Yes	
☐	☐	Routine	☐	☐	Esophageal Dilatation
☐	☐	Weight gain	☐	☐	Solid food intolerance
☐	☐	Lack of weight loss	☐	☐	Reflux symptoms
☐	☐	Reduced early satiety	☐	☐	Pregnancy
☐	☐	Nausea/vomiting	☐	☐	Other *specify:* _____
☐	☐	Increased appetite/hunger			

3. Was the procedure done at bedside or under fluoroscopy? ☐ Bedside ☐ Under fluoroscopy

4. 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: ___.___ cc

5.2 Volume at the end of the procedure: ___.___ cc

6. Type of fluid in band: ☐ Saline ☐ Other *specify:* _____

7. Total time of adjustment: ___ minutes ___ seconds

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

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

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)

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 focas 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:

_____

_____

_____

_____

_____

_____

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: ☐☐ / ☐☐ / 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. Date of surgery: ☐☐ / ☐☐ / 20☐☐

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) →

   7.1 *If Gastric bypass, BPD, or BPDS:* Was this a second stage procedure following a sleeve gastrectomy?

   ☐ No ☐ Yes

   ☐ Adjustable band

   ☐ Sleeve gastrectomy - initial stage

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

   ☐ Vertical Banded Gastroplasty

   ☐ Other, specify: ☐

8. Anesthesia risk-derived classification

   ☐ Stage I ☐ Stage II ☐ Stage III ☐ Stage IV

Site ID: ☐☐☐ Subject ID: ☐☐☐☐☐

For coordinator use only.

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
☐	☐	a. Compression stockings									
☐	☐	b. Sequential compression device									
☐	☐	c. Prophylactic vena cava filter									
☐	☐	d. Foot pump									
☐	☐	e. 5000 units sub-cutaneous heparin	→ ☐	☐	☐	☐	☐	→ ☐	☐	→ ☐	☐
☐	☐	f. Other dose heparin; Dose: ☐☐☐☐☐ units	→ ☐	☐	☐	☐	☐	→ ☐	☐	→ ☐	☐
☐	☐	g. Low molecular weight heparin	→ ☐	☐	☐	☐	☐	→ ☐	☐	→ ☐	☐

↳ *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 ☐☐	☐☐☐☐.☐☐	☐☐:☐☐	☐ Pre-surg holding room	☐ Operating room
10.2 ☐☐	☐☐☐☐.☐☐	☐☐:☐☐	☐ Pre-surg holding room	☐ Operating room
10.3 ☐☐	☐☐☐☐.☐☐	☐☐:☐☐	☐ Pre-surg holding room	☐ Operating room

Antibiotic codes:

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

11. Placement of central line?

☐ No ☐ Yes

12. Placement of arterial line?

☐ No ☐ Yes

Site ID: ☐☐☐ Subject ID: ☐☐☐☐☐

For coordinator use only.

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

13. Record fluids and blood loss during surgery:

a. Crystalloid fluids: ☐☐☐☐☐ ml

b. Colloid fluids: ☐☐☐☐☐ ml

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

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:

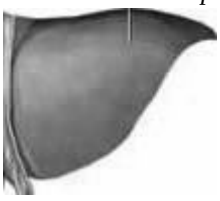
15.5.1 Splenomegaly: ☐ No ☐ Yes ☐ Could not observe

15.5.2 Varices: ☐ No ☐ Yes ☐ Could not observe

15.5.3 Other: ☐ No ☐ Yes, specify: ____

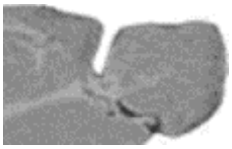
16. On a scale of 1 to 5, with 1 being gauged as normal and sharp and 5 being gauged as thick and rounded, circle the level of the sharpness of the edge of the left lateral segment of the liver.

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



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

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
☐	☐	a. Liver biopsy

↳ a1. Area of biopsy: ☐ Right lobe ☐ Left lobe ☐ Both lobes

a2. Indication for biopsy:

No	Yes	
☐	☐	Research protocol
☐	☐	Routine/standard of care
☐	☐	Signs or symptoms of liver disease
☐	☐	Abnormal pre-op LFTs
☐	☐	Abnormal appearance of liver in O.R.
☐	☐	Other, specify:

a3. Were there any complications? No ☐ Yes ☐ → If complication, specify:

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

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 ☐ Yes

20.2 Width of fascial defect (largest dimension): ☐☐.☐☐ cm

21. Lowest reported body temperature:

☐☐.☐☐ °C → 21.1 Specify temperature source: ☐ Skin (including cartilage) ☐ Core

22. 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 ☐ ☐ Gastrojejunostomy; No Yes ☐ ☐ Jejunostomy; No Yes ☐ ☐ Other *specify:*
☐	☐	22.5 Instrument/equipment failure ↳ 22.5.1 Specify cause *(mark "No" or "Yes" to each)*: No Yes ☐ ☐ Staple misfire; No Yes ☐ ☐ Trocar injury; No Yes ☐ ☐ Other *specify:*

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

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

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

No	Yes	**Intra-Operative Events**, ***continued***
☐	☐	22.17 Serosal tear of intestine that required repair
	↳	22.17.1 Specify number of tears: ☐☐ 22.17.2 Specify location (mark all that apply): ☐ Stomach ☐ Small bowel ☐ Colon 22.17.3 Specify method of serosal tear repair: ☐ Resection ☐ Oversew ☐ No repair necessary
☐	☐	22.18 Enterotomy
	↳	22.18.2 Specify location (mark all that apply): ☐ Stomach ☐ Small bowel ☐ Colon 22.18.3 Specify method of enterotomy repair: ☐ Resection ☐ Oversew ☐ No repair necessary
☐	☐	22.19 Cardiac arrhythmias resulting in significant change in blood pressure and pharmacological intervention
☐	☐	22.20 Cardiac arrest
☐	☐	22.21 Subcutaneous Emphysema
☐	☐	22.22 Pneumothorax
	↳	22.22.1 Did the patient require chest tube or pigtail placement? ☐ No ☐ Yes
☐	☐	22.23 Gas embolism with clinically significant gas introduced into central venous system
☐	☐	22.24 Respiratory arrest (cessation of respiratory function)
☐	☐	22.25 Respiratory failure (requiring continued mechanical ventilation)
☐	☐	22.26 Death
☐	☐	22.27 Other event that required an unexpected course of action
	↳	22.27.1 Specify other event(s) (list one per line):

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.)

Item	Specify if item was other (for 22.27)	Outcome
☐☐.☐☐		☐ Resolved ☐ Controlled ☐ Continuing ☐ Death
☐☐.☐☐		☐ Resolved ☐ Controlled ☐ Continuing ☐ Death
☐☐.☐☐		☐ Resolved ☐ Controlled ☐ Continuing ☐ Death
☐☐.☐☐		☐ Resolved ☐ Controlled ☐ Continuing ☐ Death
☐☐.☐☐		☐ Resolved ☐ Controlled ☐ Continuing ☐ Death
☐☐.☐☐		☐ Resolved ☐ Controlled ☐ Continuing ☐ Death
☐☐.☐☐		☐ Resolved ☐ Controlled ☐ Continuing ☐ Death
☐☐.☐☐		☐ Resolved ☐ Controlled ☐ Continuing ☐ Death
☐☐.☐☐		☐ Resolved ☐ Controlled ☐ Continuing ☐ Death
☐☐.☐☐		☐ Resolved ☐ Controlled ☐ Continuing ☐ Death
☐☐.☐☐		☐ Resolved ☐ Controlled ☐ Continuing ☐ Death
☐☐.☐☐		☐ Resolved ☐ Controlled ☐ Continuing ☐ Death
☐☐.☐☐		☐ Resolved ☐ Controlled ☐ Continuing ☐ Death
☐☐.☐☐		☐ Resolved ☐ Controlled ☐ Continuing ☐ Death
☐☐.☐☐		☐ Resolved ☐ Controlled ☐ Continuing ☐ Death
☐☐.☐☐		☐ Resolved ☐ Controlled ☐ Continuing ☐ 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.

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

APPENDIX A
Bariatric Anesthesia Events

Code	Event	Code	Event
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 gastronintestinal tract by esophageal probes	48	Miscellaneous

APPENDIX B
Injury Scales

6. Diaphragm injury scale		
Grade	**Injury Description**	**AIS-90**
I	Contusion	2
II	Laceration <=2cm	3
III	Laceration 2-10 cm	3
IV	Laceration >10 cm with tissue loss <=25cm²	3
V	Laceration with tissue loss >25 cm²	3

7. Liver injury scale - laceration		
Grade	**Injury Description**	**AIS-90**
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

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

APPENDIX B, continued
Injury Scales

8. Spleen scale - laceration		
Grade	**Injury Description**	**AIS-90**
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 devscularization (>25% of spleen)	4
V	Complete shattered spleen	5

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

11. Urethra injury - laceration			
Grade	**Injury Type**	**Injury Description**	**AIS-90**
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 transaction with >2 cm urethral separation, or extension into the prostate or vagina	4

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

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

15. Bowel injury		
Grade	**Injury Description**	**AIS-90**
I	Contusion or hematoma withour 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: ☐☐ / ☐☐ / 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. 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? No	Prophylactic (preventative) Use? Yes	# of days	times per day	Therapeutic (as treatment) Use? No	Therapeutic (as treatment) Use? Yes	# of days	times per day
☐	☐	5000 units sub-cutaneous heparin	→	☐	☐	☐☐	☐☐	☐	☐	☐☐	☐☐
☐	☐	Other dose heparin; Dose: ☐☐☐☐☐ units	→	☐	☐	☐☐	☐☐	☐	☐	☐☐	☐☐
☐	☐	Low molecular weight heparin *If yes, specify dose:* ☐ 20 mg ☐ 40 mg ☐ 60 mg ☐ Other, specify: ☐☐☐.☐☐ mg	→	☐	☐	☐☐	☐☐	☐	☐	☐☐	☐☐
☐	☐	Other Anticoagulant *If yes, specify:* Name: ☐☐☐☐☐☐☐☐☐☐ Dose: ☐☐☐.☐☐ ☐ mg ☐ units	→	☐	☐	☐☐	☐☐	☐	☐	☐☐	☐☐

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

No	Yes		No	Yes	
☐	☐	Thoracic epidural	☐	☐	Oral narcotics
☐	☐	Abdominal epidural	☐	☐	Intermittent IV narcotics
☐	☐	Patient controlled anesthesia (PCA) pump	☐	☐	Tylenol
☐	☐	Roxicet Elixir	☐	☐	Ketorolac
			☐	☐	Other, specify: ☐☐☐☐☐☐☐☐☐☐

3. Patient disposition after surgery:

☐ ICU →
☐ Floor with telemetry
☐ Floor without telemetry
☐ Same day discharge

If ICU,

3.1 Specify number of days of intubation after surgery: ☐☐
(day of surgery is defined as day zero)

3.2 Was the patient reintubated? ☐ No ☐ Yes → If yes, number of times: ☐☐

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

5. Was the patient discharged more than 30 days AFTER initial surgery?
☐ No ☐ Yes

6. Date of hospital discharge (or date of death if patient died prior to discharge): ☐☐ / ☐☐ / 20☐☐

7. Intended discharge location:
☐ Home ☐ Other hospital
☐ Rehabilitation facility ☐ Was not discharged (patient died prior to discharge)
☐ Skilled nursing facility

8. Did the patient have any in-hospital Post-Operative Complications prior to discharge?
☐ No → *End of questionnaire*
☐ Yes → *Complete the following table. Mark "No" or "Yes" to each item.*
If patient was discharged more than 30 days AFTER initial surgery, mark the "Within 30 days" box if complication occurred WITHIN 30 days of surgery.

No	Yes	Within 30 days	Post-operative complications
☐	☐ ↳	☐	8.1 Reoperation ***(NOTE: for each re-operation, please obtain adjudication information)***

8.1.1 Specify reason for surgery *(mark "No" or "Yes" for each).*

No	Yes		No	Yes	
☐	☐	a. Intestinal obstruction	☐	☐	i. Wound infection/evisceration
☐	☐	b. Subsequent cholecystectomy	☐	☐	j. Fluid or electrolyte depletion
☐	☐	c. Anastomotic leak	☐	☐	k. Vomiting or poor intake
☐	☐	d. Other abdominal sepsis	☐	☐	l. Gastric distension
☐	☐	e. Pulmonary embolism	☐	☐	m. Strictures
☐	☐	f. Pneumonia	☐	☐	n. Bleeding
☐	☐	g. Other respiratory failure	☐	☐	o. Infection/fever
☐	☐	h. Subsequent abdominoplasty	☐	☐	p. Other, specify: ☐☐☐☐☐☐☐☐☐☐

☐	☐ ↳	☐	8.2 Gastrojejunostomy leak

8.2.1 Specify grade: ☐ Minimal - small contained leak, patient asymptomatic
☐ Moderate - moderate size forming collection, symptomatic, drain used
☐ Large - not contained, symptomatic, requires re-operation

☐	☐ ↳	☐	8.3 Jejuno-jejunostomy leak

8.3.1 Specify grade: ☐ Minimal - small contained leak, patient asymptomatic
☐ Moderate - moderate size forming collection, symptomatic, drain used
☐ Large - not contained, symptomatic, requires re-operation

☐	☐	☐	8.4 Pancreatitis

Teen-LABS (DS) Discharge Summary

8. Post-Operative Complications (continued)

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

Teen-LABS (DS) Discharge Summary

8. Post-Operative Complications (continued)

No	Yes	Within 30 days	Post-operative complications
☐	☐	☐	8.19 Deep vein thrombosis
☐	☐	☐	8.20 Pneumonia
☐	☐	☐	8.21 Respiratory failure requiring intubation
	↳		8.21.1 Specify cause: ☐ ARDS ☐ PE ☐ Other, specify: ☐ Pneumonia ☐ Unknown
☐	☐	☐	8.22 Renal/urinary tract infection
☐	☐	☐	8.23 Renal failure
	↳		8.23.1 Specify type of diagnosis *(mark "No" or "Yes" for each)*. No ☐ Yes ☐ Oliguric/anuric No ☐ Yes ☐ Creatinine
☐	☐	☐	8.24 TIA
☐	☐	☐	8.25 Stroke
	↳		8.25.1 Specify type of diagnosis: ☐ Ischemic ☐ Hemorrhagic
☐	☐	☐	8.26 Urinary retention
☐	☐	☐	8.27 New decubitus ulcers (bed sores)
☐	☐	☐	8.28 Rhabodomyolysis (defined as CPK's of 5000 or more)
☐	☐	☐	8.29 Jaundice
☐	☐	☐	8.30 Hepatitis
☐	☐	☐	8.31 Liver failure
☐	☐	☐	8.32 Acute cholecystitis/bilaric colic
☐	☐	☐	8.33 Common bile duct stones/cholangitis
☐	☐	☐	8.34 Arrhythmia
☐	☐	☐	8.35 Persistent Tachycardia
☐	☐	☐	8.36 Myocardial infarction
☐	☐	☐	8.37 Cardiac arrest
☐	☐	☐	8.38 Death ***(Please obtain adjudication information)***
☐	☐	☐	8.39 Other event that resulted in an unexpected course of action, specify:

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**
☐.☐.☐☐		☐☐ / ☐☐ / ☐☐	☐ Resolved ☐ Controlled ☐ Continuing ☐ Death
☐.☐.☐☐		☐☐ / ☐☐ / ☐☐	☐ Resolved ☐ Controlled ☐ Continuing ☐ Death
☐.☐.☐☐		☐☐ / ☐☐ / ☐☐	☐ Resolved ☐ Controlled ☐ Continuing ☐ Death
☐.☐.☐☐		☐☐ / ☐☐ / ☐☐	☐ Resolved ☐ Controlled ☐ Continuing ☐ Death
☐.☐.☐☐		☐☐ / ☐☐ / ☐☐	☐ Resolved ☐ Controlled ☐ Continuing ☐ Death

Use this table for items 8.2 through 8.39

Item	**Specify if item was other**	**Date** *(mm/dd/yy)*	**Outcome**
☐.☐☐		☐☐ / ☐☐ / ☐☐	☐ Resolved ☐ Controlled ☐ Continuing ☐ Death
☐.☐☐		☐☐ / ☐☐ / ☐☐	☐ Resolved ☐ Controlled ☐ Continuing ☐ Death
☐.☐☐		☐☐ / ☐☐ / ☐☐	☐ Resolved ☐ Controlled ☐ Continuing ☐ Death
☐.☐☐		☐☐ / ☐☐ / ☐☐	☐ Resolved ☐ Controlled ☐ Continuing ☐ Death
☐.☐☐		☐☐ / ☐☐ / ☐☐	☐ Resolved ☐ Controlled ☐ Continuing ☐ Death
☐.☐☐		☐☐ / ☐☐ / ☐☐	☐ Resolved ☐ Controlled ☐ Continuing ☐ Death
☐.☐☐		☐☐ / ☐☐ / ☐☐	☐ Resolved ☐ Controlled ☐ Continuing ☐ Death
☐.☐☐		☐☐ / ☐☐ / ☐☐	☐ Resolved ☐ Controlled ☐ Continuing ☐ Death
☐.☐☐		☐☐ / ☐☐ / ☐☐	☐ Resolved ☐ Controlled ☐ Continuing ☐ Death
☐.☐☐		☐☐ / ☐☐ / ☐☐	☐ Resolved ☐ Controlled ☐ Continuing ☐ 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	☐	☐	→	☐☐ / ☐☐ / ☐☐
b. Patient by telephone	☐	☐	→	☐☐ / ☐☐ / ☐☐
c. Patient representative	☐	☐	→	☐☐ / ☐☐ / ☐☐
d. Other physician	☐	☐	→	☐☐ / ☐☐ / ☐☐
e. Chart review	☐	☐	→	☐☐ / ☐☐ / ☐☐

2. Length of hospital stay for obesity surgery:
☐☐☐ days

3. Discharge location:
- ☐ Home →
- ☐ Rehabilitation facility →
- ☐ Skilled nursing facility →
- ☐ Other hospital →

3.1 Discharge date: ☐☐ / ☐☐ / ☐☐☐☐

- ☐ Was not discharged

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 ☐ Yes

5.4 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

Teen-LABS (POST) Post-Operative Evaluation Form

7. Did the patient have any post-discharge complications?

☐ No → *Skip to question 9 on page 5*

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

No	Yes	Post-discharge complications
☐	☐	7.1 Wound infection
☐	☐	7.2 Fascial dehiscence
		↳ 7.2.1 Did the wound edges open within 30 days following surgery? ☐ No ☐ Yes 7.2.2 Did the wound edges separate within 30 days following the surgery requiring packing or bandage? ☐ No ☐ Yes
☐	☐	7.3 Small bowel obstruction
		↳ 7.3.1 Specify obstruction: ☐ Partial obstruction ☐ Complete obstruction 7.3.2 Specify cause: ☐ Internal hernia ☐ Anastomotic anatomy ☐ Unknown ☐ Adhesions ☐ Obstructed JJ Anastomosis ☐ Other, specify:
☐	☐	7.4 Incisional/ventral hernia
☐	☐	7.5 Acute cholecystitis/bilaric colic
☐	☐	7.6 Common bile duct stones/cholangitis
☐	☐	7.7 Stomal/gastric outlet obstruction
☐	☐	7.8 Stapleline breakdown
☐	☐	7.9 Leakage of intestinal contents

↳ 7.9.1 Specify details of leak *(mark "No" or "Yes" to each).*

No	Yes		No	Yes	
☐	☐	a. Contained	☐	☐	k. From esophagus
☐	☐	b. Diffuse	☐	☐	l. From stomach
☐	☐	c. Staple line	☐	☐	m. From small bowel
☐	☐	d. Operative repair or drainage	☐	☐	m. From JJ
☐	☐	e. Percutaneous drainage	☐	☐	n. From other source, specify:
☐	☐	f. Non-operative management			
☐	☐	g. Proximal to GJ junction	☐	☐	o. Duodenum or biliopancreatic limb
☐	☐	h. Gastrojejunostomy anastomosis	☐	☐	p. Roux (not anastomosis)
☐	☐	i. Gastric pouch	☐	☐	q. Common channel small bowel
☐	☐	j. Gastric remnant			

☐	☐	7.10 Anastomotic stricture: Gastro-jejunostomy
☐	☐	7.11 Anastomotic stricture: Jejuno-jejunostomy
☐	☐	7.12 Gastric band stenosis
☐	☐	7.13 Gastric band erosion
☐	☐	7.14 Gastric band slippage
☐	☐	7.15 Gastric band leakage

Teen-LABS (POST) Post-Operative Evaluation Form

7. Post discharge complications, continued.

No	Yes	Post-discharge complications
☐	☐	7.16 Port or tube problems
☐	☐	7.17 Gastric prolapse
☐	☐	7.18 Esophageal motility disorder or dilation
☐	☐	7.19 Gastroesophageal reflux

↳ 7.19.1 How was it identified:
☐ Symptoms ☐ pH probe → # measured: ☐☐☐

No	Yes	Post-discharge complications
☐	☐	7.20 Primary dumping syndrome *(including nausea, bloating, diarrhea, colic, within 1 hour of a meal)*
☐	☐	7.21 Late-dumping symptoms *(including light-headedness, palpitations, sweating, diarrhea, >=1 hour of a meal)*
☐	☐	7.22 Nausea or vomiting

↳ 7.22.1 Specify severity and frequency levels

	Severity level*					Frequency level**				
	None	Mild	Moderate	Severe	Extremely severe	None	Rare	Occasional	Frequent	Extremely frequent
Nausea	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Vomiting	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

*Severity definitions
None: does not have this complication.
Mild: not influencing usual activitites.
Moderate: diverting from, but not urging modification.
Severe: influencing usual activitites, severely enough urge modifications.
Extremely severe: requiring hospitalization or bed rest.

*Frequency definitions
None: does not have this complication.
Rare: 1 time per week.
Occasional: 2 to 3 times per week.
Frequent: 4 to 6 times per week.
Extremely frequent: 7 or more times per week.

No	Yes	Post-discharge complications
☐	☐	7.23 Flatulence *(defined as excessive interference with lifestyle)*
☐	☐	7.24 Persistent diarrhea *(defined as excessive interference with lifestyle)*
☐	☐	7.25 Constipation *(defined as excessive interference with lifestyle)*
☐	☐	7.26 Dehydration *(defined as requiring hospitalization)*
☐	☐	7.27 Acute renal failure
☐	☐	7.28 Liver failure
☐	☐	7.29 Myocardial infarction
☐	☐	7.30 Cardiac arrest
☐	☐	7.31 Hypoglycemia *(defined by abnormally low blood glucose measured within 3 hours after a meal)*
☐	☐	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)*
☐	☐	7.33 Other event that resulted in an unexpected course of action, specify:

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 occurrance, 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
☐.☐☐		☐☐ / ☐☐ / ☐☐	☐ Resolved ☐ Controlled ☐ Continuing ☐ Death
☐.☐☐		☐☐ / ☐☐ / ☐☐	☐ Resolved ☐ Controlled ☐ Continuing ☐ Death
☐.☐☐		☐☐ / ☐☐ / ☐☐	☐ Resolved ☐ Controlled ☐ Continuing ☐ Death
☐.☐☐		☐☐ / ☐☐ / ☐☐	☐ Resolved ☐ Controlled ☐ Continuing ☐ Death
☐.☐☐		☐☐ / ☐☐ / ☐☐	☐ Resolved ☐ Controlled ☐ Continuing ☐ Death
☐.☐☐		☐☐ / ☐☐ / ☐☐	☐ Resolved ☐ Controlled ☐ Continuing ☐ Death
☐.☐☐		☐☐ / ☐☐ / ☐☐	☐ Resolved ☐ Controlled ☐ Continuing ☐ Death
☐.☐☐		☐☐ / ☐☐ / ☐☐	☐ Resolved ☐ Controlled ☐ Continuing ☐ Death
☐.☐☐		☐☐ / ☐☐ / ☐☐	☐ Resolved ☐ Controlled ☐ Continuing ☐ Death
☐.☐☐		☐☐ / ☐☐ / ☐☐	☐ Resolved ☐ Controlled ☐ Continuing ☐ Death
☐.☐☐		☐☐ / ☐☐ / ☐☐	☐ Resolved ☐ Controlled ☐ Continuing ☐ Death
☐.☐☐		☐☐ / ☐☐ / ☐☐	☐ Resolved ☐ Controlled ☐ Continuing ☐ Death
☐.☐☐		☐☐ / ☐☐ / ☐☐	☐ Resolved ☐ Controlled ☐ Continuing ☐ 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

Teen-LABS (POST) Post-Operative Evaluation Form

9. Did the patient have any post-discharge procedures or undergo unplanned post-discharge anticoagulation therapy?

☐ No ☐ Yes → *Specify all of the bariatric procedures or anticoagulation therapies below. Mark "No" or "Yes" to each item.*

Event			Date first performed after surgery *(mm/dd/yy)*	Suspected reason for intervention *(see codes on page 4)*	Was the reason for the intervention confirmed?	
No	**Yes**				**No**	**Yes**
☐	☐	9.1 Abdominal re-operation				
	↳	9.1.1 Specify approach: ☐ Laparoscopic ☐ Laparoscopic converted to open ☐ Open				
		9.1.2 Specify procedure:				
No	**Yes**					
☐	☐	a. Operative drain placement	☐☐/☐☐/☐☐	☐☐	☐	☐
☐	☐	b. Gastrostomy	☐☐/☐☐/☐☐	☐☐	☐	☐
☐	☐	c. Anastomotic revision				
		Specify revision: ☐ GJ	☐☐/☐☐/☐☐	☐☐	☐	☐
		☐ JJ	☐☐/☐☐/☐☐	☐☐	☐	☐
		☐ DJ	☐☐/☐☐/☐☐	☐☐	☐	☐
☐	☐	d. Band replacement	☐☐/☐☐/☐☐	☐☐	☐	☐
☐	☐	e. Band/port revision	☐☐/☐☐/☐☐	☐☐	☐	☐
☐	☐	f. Wound revision or evisceration	☐☐/☐☐/☐☐	☐☐	☐	☐
☐	☐	g. Re-exploration	☐☐/☐☐/☐☐	☐☐	☐	☐
☐	☐	h. Other *specify:*	☐☐/☐☐/☐☐	☐☐	☐	☐
☐	☐	9.2 Tracheal reintubation	☐☐/☐☐/☐☐	☐☐	☐	☐
☐	☐	9.3 Tracheostomy	☐☐/☐☐/☐☐	☐☐	☐	☐
☐	☐	9.4 Endoscopy	☐☐/☐☐/☐☐	☐☐	☐	☐
☐	☐	9.5 Dilation	☐☐/☐☐/☐☐	☐☐	☐	☐
☐	☐	9.6 Placement of percutaneous drain	☐☐/☐☐/☐☐	☐☐	☐	☐
☐	☐	9.7 Anticoagulation therapy for presumed/confirmed DVT			☐	☐
☐	☐	9.8 Anticoagulation therapy for presumed/confirmed PE			☐	☐
☐	☐	9.9 Readmission (other 1) *specify:*	☐☐/☐☐/☐☐	☐☐	☐	☐
☐	☐	9.10 Readmission (other 2) *specify:*	☐☐/☐☐/☐☐	☐☐	☐	☐
☐	☐	9.11 Readmission (other 3) *specify:*	☐☐/☐☐/☐☐	☐☐	☐	☐

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 occurrance. 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*

Item	Specify if item was other	Date *(mm/dd/yy)*
__ . __ . ____		__ / __ / __
__ . __ . ____		__ / __ / __
__ . __ . ____		__ / __ / __
__ . __ . ____		__ / __ / __
__ . __ . ____		__ / __ / __
__ . __ . ____		__ / __ / __
__ . __ . ____		__ / __ / __
__ . __ . ____		__ / __ / __
__ . __ . ____		__ / __ / __
__ . __ . ____		__ / __ / __

****Please obtain adjudication information***

Use this table for items 9.2 through 9.11*

Item	Specify if item was other	Date *(mm/dd/yy)*
__ . __		__ / __ / __
__ . __		__ / __ / __
__ . __		__ / __ / __
__ . __		__ / __ / __
__ . __		__ / __ / __
__ . __		__ / __ / __
__ . __		__ / __ / __
__ . __		__ / __ / __
__ . __		__ / __ / __
__ . __		__ / __ / __

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) Use? No	Prophylactic (preventative) Use? Yes	# of days	times per day	Therapeutic (as treatment) Use? No	Therapeutic (as treatment) Use? Yes	# of days	times per day
☐	☐	5000 units sub-cutaneous heparin	→	☐	☐	☐☐	☐☐	☐	☐	☐☐	☐☐
☐	☐	Other dose heparin; Dose: ☐☐☐☐☐ units	→	☐	☐	☐☐	☐☐	☐	☐	☐☐	☐☐
☐	☐	Low molecular weight heparin *If yes, specify dose:* ☐ 20 mg ☐ 40 mg ☐ 60 mg ☐ Other, specify: ☐☐☐.☐☐ mg	→	☐	☐	☐☐	☐☐	☐	☐	☐☐	☐☐
☐	☐	Other Anticoagulant *If yes, specify:* Name: ☐ Dose: ☐☐☐.☐☐ ☐ mg ☐ units	→	☐	☐	☐☐	☐☐	☐	☐	☐☐	☐☐

Site ID: _____ Subject ID: _____ Reviewed by (certification no.): _____
Visit: _____ 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: ☐☐ / ☐☐ / 2 0 ☐☐ *(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 respondant):

☐ 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

No	Yes	
☐	☐	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)

No	Yes	
☐	☐	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: ☐

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

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

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

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

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

Visit: ☐☐ HC ID: ☐☐ **For coordinator use only.** Review date: ☐☐ / ☐☐ / ☐☐

Teen-LABS (HC) Health Care Utilization 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: ☒

INSTRUCTIONS: This form should be completed for <u>each</u> hospitalization, out-patient procedure, or re-intervention that was reported by the patient *<u>since their last visit.</u>* *Note: if a participant missed their last visit, this will cover a longer time frame going back to the last visit they did have.*
For each visit, make sure to assign a unique HC ID (in form header) for each HC. This HC ID is used for reference only.

1. Name and address of hospital/clinic:

Name

Address

City (please do NOT abbreviate) *State* *Zip*

2. Admission/treatment date: ☐☐ / ☐☐ / 20☐☐ *(mm/dd/yyyy)*

3. Treatment/care utilized:

☐ Hospitalization →
☐ Out-patient procedure
☐ Re-intervention

For hospitalization only (NOTE: also obtain adjudication information for this hospitalization):

3.1 Discharge location: ☐ Home
☐ Rehabilitation facility
☐ Skilled nursing facility
☐ Other hospital
☐ Other *specify:*

3.2 Discharge date: ☐☐ / ☐☐ / ☐☐☐☐ *(mm/dd/yyyy)*

3.3 If not discharged to home, specify length of care at facility: ☐☐ days

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

No	Yes	
☐	☐	**4.1 GI Tract or Bariatric Surgery Related Diagnoses**

↳ *Mark "Yes" or "No" to each.*

No	Yes		No	Yes	
☐	☐	a. Stomal/gastric outlet obstruction	☐	☐	j. Hernia with complication
☐	☐	b. Small bowel obstruction	☐	☐	k. Abdominal pain
☐	☐	c. Deep wound infection	☐	☐	l. Abdominal abscess
☐	☐	d. Other wound complication	☐	☐	m. Ulcer disease
☐	☐	e. Infection from GI leak	☐	☐	n. Nausea and vomiting
☐	☐	f. GI bleeding	☐	☐	o. Excess skin
☐	☐	g. GI tract symptoms	☐	☐	p. Other GI tract or surgery related diagnosis
☐	☐	h. Hypovolemia			*specify:*
☐	☐	i. Hernia without complication			

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.

No	Yes		No	Yes	
☐	☐	a. Acute renal failure	☐	☐	e. Other renal system related diagnosis *specify:*
☐	☐	b. Kidney failure or start of dialysis			
☐	☐	c. Severe hypoglycemia			
☐	☐	d. Pancreatitis			

No	Yes	
☐	☐	**4.3 Vascular System Diagnoses**

Mark "Yes" or "No" to each.

No	Yes		No	Yes	
☐	☐	a. Chest pain or angina	☐	☐	e. PE/DVT
☐	☐	b. Myocardial infarction	☐	☐	f. Other vascular system related diagnosis *specify:*
☐	☐	c. Congestive heart disease			
☐	☐	d. TIA/Stroke			

No	Yes	
☐	☐	**4.4 Respiratory System Diagnoses**

Mark "Yes" or "No" to each.

No	Yes		No	Yes	
☐	☐	a. Acute respiratory failure	☐	☐	e. Pneumonia
☐	☐	b. Pulmonary Hypertension	☐	☐	f. Other respiratory system related diagnosis *specify:*
☐	☐	c. COPD			
☐	☐	d. Obstructive lung disease			

No	Yes	
☐	☐	**4.5 Obesity-Related Diagnoses**

Mark "Yes" or "No" to each.

No	Yes		No	Yes	
☐	☐	a. Osteoarthritis	☐	☐	c. Other obesity related diagnosis *specify:*
☐	☐	b. Cellulitis			

No	Yes	
☐	☐	**4.6 Other Diagnoses**

Mark "Yes" or "No" to each.

No	Yes		No	Yes	
☐	☐	a. Gallbladder disease	☐	☐	d. Other diagnosis not listed above *specify:*
☐	☐	b. Local adiposity			
☐	☐	c. Activity-related injury			

Site ID: ☐☐☐ Subject ID: ☐☐☐☐☐

Visit: ☐☐ HC ID: ☐☐ **For coordinator use only.**

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 occurrance, 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**
☐.☐☐		☐☐ / ☐☐ / ☐☐	☐ Resolved ☐ Controlled ☐ Continuing ☐ Death
☐.☐☐		☐☐ / ☐☐ / ☐☐	☐ Resolved ☐ Controlled ☐ Continuing ☐ Death
☐.☐☐		☐☐ / ☐☐ / ☐☐	☐ Resolved ☐ Controlled ☐ Continuing ☐ Death
☐.☐☐		☐☐ / ☐☐ / ☐☐	☐ Resolved ☐ Controlled ☐ Continuing ☐ Death
☐.☐☐		☐☐ / ☐☐ / ☐☐	☐ Resolved ☐ Controlled ☐ Continuing ☐ Death
☐.☐☐		☐☐ / ☐☐ / ☐☐	☐ Resolved ☐ Controlled ☐ Continuing ☐ Death
☐.☐☐		☐☐ / ☐☐ / ☐☐	☐ Resolved ☐ Controlled ☐ Continuing ☐ Death
☐.☐☐		☐☐ / ☐☐ / ☐☐	☐ Resolved ☐ Controlled ☐ Continuing ☐ Death
☐.☐☐		☐☐ / ☐☐ / ☐☐	☐ Resolved ☐ Controlled ☐ Continuing ☐ Death
☐.☐☐		☐☐ / ☐☐ / ☐☐	☐ Resolved ☐ Controlled ☐ Continuing ☐ Death
☐.☐☐		☐☐ / ☐☐ / ☐☐	☐ Resolved ☐ Controlled ☐ Continuing ☐ Death
☐.☐☐		☐☐ / ☐☐ / ☐☐	☐ Resolved ☐ Controlled ☐ Continuing ☐ Death
☐.☐☐		☐☐ / ☐☐ / ☐☐	☐ Resolved ☐ Controlled ☐ Continuing ☐ 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.

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.*

No	Yes		No	Yes	
☐	☐	a. Upper GI tract endoscopy	☐	☐	n. Placement of percutaneous drain
☐	☐	b. Stricture dilation	☐	☐	o. Re-exploration
☐	☐	c. Ventral hernia repair	☐	☐	p. Other revision of bariatric surgery *specify:*
☐	☐	d. Exploratory laparatomy			
☐	☐	e. Wound incision, evisceration or revision			
☐	☐	f. Wound drainage	☐	☐	q. Reversal of bariatric surgery *specify:*
☐	☐	g. Lysis of adhesions			
☐	☐	h. Gastric revision			
☐	☐	i. Gastrostomy			
☐	☐	j. Anastomotic revision	☐	☐	r. Removal of excess skin
☐	☐	k. Band/port revision	☐	☐	s. Other GI tract or bariatric surgery related procedure, specify:
☐	☐	l. Band replacement			
☐	☐	m. Operative drain placement			

☐ ☐ **7.2 Renal System Procedures**

↳ *Mark "Yes" or "No" to each.*

No	Yes		
☐	☐	a. Dialysis	
☐	☐	b. Other renal system related procedure	*specify:*

☐ ☐ **7.3 Vascular System Procedures**

↳ *Mark "Yes" or "No" to each.*

No	Yes		No	Yes	
☐	☐	a. Cardiac catheterization	☐	☐	e. Other vascular system related procedure, specify:
☐	☐	b. Percutaneous coronary intervention/angioplasty			
☐	☐	c. Coronary artery bypass graft surgery			
☐	☐	d. Peripheral vascular catheter-based intervention			

☐ ☐ **7.4 Respiratory System Procedures**

↳ *Mark "Yes" or "No" to each.*

No	Yes		No	Yes	
☐	☐	a. Mechanical ventilation	☐	☐	c. Other respiratory system related procedure, specify:
☐	☐	b. Supplemental oxygen			

Site ID: ☐☐☐ Subject ID: ☐☐☐☐☐

Visit: ☐☐ HC ID: ☐☐ **For coordinator use only.**

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.*

No	Yes		No	Yes	
☐	☐	a. Cholecystectomy	☐	☐	e. Liposuction or liposculpture
☐	☐	b. Orthopedic procedure	☐	☐	f. Other elective procedure, specify:
☐	☐	c. Hysterectomy procedure			
☐	☐	d. Plastic procedures other than removal of excess skin			

No	Yes	
☐	☐	**7.6 Other Procedures**

↳ *Mark "Yes" or "No" to each.*

No	Yes	
☐	☐	a. Non-elective procedure not specified *specify:*

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:

☐ Laparascopic ☐ 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 occurrance. If a procedure occurred more than once, record EACH INSTANCE on a separate line.

Item	**Specify if item was other**	**Date** *(mm/dd/yy)*
☐.☐☐		☐☐/☐☐/☐☐
☐.☐☐		☐☐/☐☐/☐☐
☐.☐☐		☐☐/☐☐/☐☐
☐.☐☐		☐☐/☐☐/☐☐
☐.☐☐		☐☐/☐☐/☐☐
☐.☐☐		☐☐/☐☐/☐☐
☐.☐☐		☐☐/☐☐/☐☐
☐.☐☐		☐☐/☐☐/☐☐

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

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

Teen-LABS (INF) Inactivation 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. Date of Inactivation: ___ / ___ / 20___ *(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 surgery

3. If not known to be deceased, status date: ___ / ___ / _____ *(mm/dd/yyyy)*
   (Most recent date participant known to be alive.)

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

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

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

Form completion date: __ __ / __ __ / 2 0 __ __ *(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.

Form: ☐☐☐☐ Form completion date: ☐☐ / ☐☐ / ☐☐ Visit reported: ☐☐ Comp/dx code: ☐ Date of complication/dx: ☐☐ / ☐☐ / ☐☐

Complication/ diagnosis description: ☐

DCC Comp ID: ☐☐☐☐☐

STATUS:
- ☐ Resolved
- ☐ Continuing
- ☐ Controlled
- ☐ Death
- ☐ Unknown

Form: ☐☐☐☐ Form completion date: ☐☐ / ☐☐ / ☐☐ Visit reported: ☐☐ Comp/dx code: ☐ Date of complication/dx: ☐☐ / ☐☐ / ☐☐

Complication/ diagnosis description: ☐

DCC Comp ID: ☐☐☐☐☐

STATUS:
- ☐ Resolved
- ☐ Continuing
- ☐ Controlled
- ☐ Death
- ☐ Unknown

Form: ☐☐☐☐ Form completion date: ☐☐ / ☐☐ / ☐☐ Visit reported: ☐☐ Comp/dx code: ☐ Date of complication/dx: ☐☐ / ☐☐ / ☐☐

Complication/ diagnosis description: ☐

DCC Comp ID: ☐☐☐☐☐

STATUS:
- ☐ Resolved
- ☐ Continuing
- ☐ Controlled
- ☐ Death
- ☐ Unknown

Form: ☐☐☐☐ Form completion date: ☐☐ / ☐☐ / ☐☐ Visit reported: ☐☐ Comp/dx code: ☐ Date of complication/dx: ☐☐ / ☐☐ / ☐☐

Complication/ diagnosis description: ☐

DCC Comp ID: ☐☐☐☐☐

STATUS:
- ☐ Resolved
- ☐ Continuing
- ☐ Controlled
- ☐ Death
- ☐ Unknown

Form: ☐☐☐☐ Form completion date: ☐☐ / ☐☐ / ☐☐ Visit reported: ☐☐ Comp/dx code: ☐ Date of complication/dx: ☐☐ / ☐☐ / ☐☐

Complication/ diagnosis description: ☐

DCC Comp ID: ☐☐☐☐☐

STATUS:
- ☐ Resolved
- ☐ Continuing
- ☐ Controlled
- ☐ Death
- ☐ Unknown

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

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

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.*

_____

_____

_____

_____

_____

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.***

_____ ___ / ___ / 20___

Signature Date (mm/dd/yyyy)

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 unantici-pated?	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
__ __ / __ __ / __ __	__ *If other (60), specify:*	__ *If other (99), specify:*	__	☐ No ☐ Yes	__	__ *If other (4), specify:*	__ __ / __ __ / __ __	__
__ __ / __ __ / __ __	__ *If other (60), specify:*	__ *If other (99), specify:*	__	☐ No ☐ Yes	__	__ *If other (4), specify:*	__ __ / __ __ / __ __	__
__ __ / __ __ / __ __	__ *If other (60), specify:*	__ *If other (99), specify:*	__	☐ No ☐ Yes	__	__ *If other (4), specify:*	__ __ / __ __ / __ __	__

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 occured.

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

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

Teen-LABS (MRF) Mortality Report 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: ☒

Supplied by the DCC:

Date of death: ___ / ___ / 20___ Date of Bariatric Surgery: ___ / ___ / 20___

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

- ☐ Bleeding
- ☐ Evisceration
- ☐ Sepsis from anastomotic leak
- ☐ Pneumonia
- ☐ Sepsis from other abdominal source
- ☐ Respiratory failure, including ARDS
- ☐ Pulmonary embolus
- ☐ Accident → *end questionnaire*
- ☐ Cardiac failure
- ☐ Suicide → *end questionnaire*
- ☐ Myocardial infarction
- ☐ Other *specify:* _____
- ☐ Cerebrovascular accident
- ☐ Indeterminate
- ☐ 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 →

☐ Indeterminate

3.1 Specify **procedure** directly related to the complication. *(Mark "No" or "Yes" for each.)*

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

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

☐ Definite ☐ Probable ☐ Indeterminate

3.3 Specify **complication** directly related to the death. *(Mark "No" or "Yes" for each.)*

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

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

☐ Definite ☐ Probable ☐ Indeterminate

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

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

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: ☐☐

Total from page 1: ☐☐

Total from page 2: ☐☐

Total: ☐☐

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	☐ No	☐ Yes	___ / ___ / ___	___ : ___	_____
Site Psychologist or PI verbally informed of situation	☐ No	☐ Yes	___ / ___ / ___	___ : ___	_____

If Total score >=20
ACTION PLAN - Coordinator Checklist

	Done		Date *(mm/dd/yy)*	Time (24hr)	Certification # of Psychologist
Site Psychologist contacted within 24 hours	☐ No	☐ Yes	___ / ___ / ___	___ : ___	_____
Site Psychologist contacted family within 1 week and made referral	☐ No	☐ Yes	___ / ___ / ___	___ : ___	_____

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

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

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

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:
   - ☐ Mother
   - ☐ Father
   - ☐ Step-mother
   - ☐ Step-father
   - ☐ Grandmother
   - ☐ Grandfather
   - ☐ Aunt
   - ☐ Uncle
   - ☐ Female legal guardian
   - ☐ Male legal guardian
   - ☐ Other *specify:* _____

6. What is your current marital status?
   - ☐ Single
   - ☐ Married
   - ☐ Living with partner
   - ☐ Separated
   - ☐ Divorced
   - ☐ Widowed

Site ID: ☐☐☐ Subject ID: ☐☐☐☐☐

Visit: ☐☐ **For coordinator use only.**

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?

☐ Full-time (35 or more hours per week) for pay ☐ Leave of Absense

☐ Part-time for pay ☐ Unemployed

☐ Homemaker ☐ Retired

☐ Disabled ☐ Other *specify:* _____

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

☐ No ☐ Yes →

↓

Skip to uestion 12 on page 4

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

☐ Husband/Participant's biological father ☐ My partner (boyfriend/girlfriend/fiance)

☐ Wife/Participant's biological mother ☐ Participant's grandfather

☐ Husband/Participant's step-father ☐ Participant's grandmother

☐ Wife/Participant's step-mother ☐ Other, specify:

_____

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
☐ Black or African-American
☐ Asian
☐ American Indian or Alaska Native
☐ Native Hawaiian or other Pacific Islander
☐ Other *specify:* _____
☐ Unknown

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
☐ Part-time for pay
☐ Homemaker
☐ Disabled
☐ Leave of Absense
☐ Unemployed
☐ Retired
☐ 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	
☐	☐	Medicaid HMO
☐	☐	Medicaid not HMO
☐	☐	Medicare HMO
☐	☐	Medicaid Traditional
☐	☐	Tricare (Military)
☐	☐	Private Insurance HMO
☐	☐	Private Insurance not HMO
☐	☐	Other Health Insurance, specify:

_____

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

	Height	**Weight**	**Bariatric surgery?**	**When?** *(mm/dd/yy)*
Primary caregiver:	☐☐☐.☐☐ cm	☐☐☐.☐☐ kg	☐ No ☐ Yes →	☐☐/☐☐/☐☐
Secondary caregiver: ☐ N/A	☐☐☐.☐☐ cm	☐☐☐.☐☐ kg	☐ No ☐ Yes →	☐☐/☐☐/☐☐

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

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

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 **<u>past 12 months</u>**?
   - ☐ No ☐ Yes →

   3.1 Mark **all** living situations that applied to you in the **<u>past 12 months</u>**:
   - ☐ 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

4. Do you have any children, either biological or other?

☐ No → *Skip to question 5 on the next page*

☐ Yes

4.1 Please list all of your children who live in your home with you FULL time in the table below.

Child's age	Is the child biological?	Who helps in the regular care of this child? (Mark all that apply.)
☐☐ yrs & ☐☐ mos	☐ Biological ☐ Adopted/Step	☐ Child's mother/father ☐ Boyfriend/Girlfriend or Spouse ☐ Other, specify: ______ ☐ Child's grandparent(s) ☐ Daycare center or school ☐ No one helps on a regular basis
☐☐ yrs & ☐☐ mos	☐ Biological ☐ Adopted/Step	☐ Child's mother/father ☐ Boyfriend/Girlfriend or Spouse ☐ Other, specify: ______ ☐ Child's grandparent(s) ☐ Daycare center or school ☐ No one helps on a regular basis
☐☐ yrs & ☐☐ mos	☐ Biological ☐ Adopted/Step	☐ Child's mother/father ☐ Boyfriend/Girlfriend or Spouse ☐ Other, specify: ______ ☐ Child's grandparent(s) ☐ Daycare center or school ☐ No one helps on a regular basis
☐☐ yrs & ☐☐ mos	☐ Biological ☐ Adopted/Step	☐ Child's mother/father ☐ Boyfriend/Girlfriend or Spouse ☐ Other, specify: ______ ☐ Child's grandparent(s) ☐ Daycare center or school ☐ No one helps on a regular basis
☐☐ yrs & ☐☐ mos	☐ Biological ☐ Adopted/Step	☐ Child's mother/father ☐ Boyfriend/Girlfriend or Spouse ☐ Other, specify: ______ ☐ Child's grandparent(s) ☐ Daycare center or school ☐ No one helps on a regular basis

4.2 Please list any other of your children who DO NOT live in your home with you full time in the table below.

Child's age	Is the child biological?	Who does the child live with? (Mark all that apply.)	How often do you see the child?
☐☐ yrs & ☐☐ mos	☐ Biological ☐ Adopted/Step	☐ Child's mother/father ☐ Child's grandparent(s) ☐ Foster parent ☐ Other, specify: ______	☐ Daily visit ☐ Every other week ☐ Few times a week ☐ Monthly or less ☐ Weekly ☐ I do not see my child(ren), why: ______
☐☐ yrs & ☐☐ mos	☐ Biological ☐ Adopted/Step	☐ Child's mother/father ☐ Child's grandparent(s) ☐ Foster parent ☐ Other, specify: ______	☐ Daily visit ☐ Every other week ☐ Few times a week ☐ Monthly or less ☐ Weekly ☐ I do not see my child(ren), why: ______
☐☐ yrs & ☐☐ mos	☐ Biological ☐ Adopted/Step	☐ Child's mother/father ☐ Child's grandparent(s) ☐ Foster parent ☐ Other, specify: ______	☐ Daily visit ☐ Every other week ☐ Few times a week ☐ Monthly or less ☐ Weekly ☐ I do not see my child(ren), why: ______
☐☐ yrs & ☐☐ mos	☐ Biological ☐ Adopted/Step	☐ Child's mother/father ☐ Child's grandparent(s) ☐ Foster parent ☐ Other, specify: ______	☐ Daily visit ☐ Every other week ☐ Few times a week ☐ Monthly or less ☐ Weekly ☐ I do not see my child(ren), why: ______
☐☐ yrs & ☐☐ mos	☐ Biological ☐ Adopted/Step	☐ Child's mother/father ☐ Child's grandparent(s) ☐ Foster parent ☐ Other, specify: ______	☐ Daily visit ☐ Every other week ☐ Few times a week ☐ Monthly or less ☐ Weekly ☐ I do not see my child(ren), why: ______

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) →

☐ Attending junior high or high school →

6.1 What grade are you currently in (or will be in if it is now summer)? ☐☐ 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

↓

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.)*

No	Yes	
☐	☐	Better learning environment at home
☐	☐	I was suspended/expelled from school
☐	☐	Teasing and social situation
☐	☐	My health status makes it hard to attend
☐	☐	Too much walking for me
☐	☐	I have difficulty fitting into school desks
☐	☐	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)

☐ YES, I am currently attending a junior high or high school

↓

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.)*

No	Yes	
☐	☐	I am absent from school frequently
☐	☐	I am often late for school
☐	☐	I have been suspended from school
☐	☐	I have been expelled (kicked out of) school

School History

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

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

↳ Please describe:

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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.*

No	Yes		No	Yes	
☐	☐	Parents	☐	☐	Friend
☐	☐	My own job	☐	☐	Husband/Wife
☐	☐	Government funds (e.g. Social Security, Welfare)	☐	☐	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.

No	Yes		*If yes*	
☐	☐	Babysitting	→	☐☐ hours/week
☐	☐	Yard care	→	☐☐ hours/week
☐	☐	Cleaning house	→	☐☐ hours/week
☐	☐	Farmwork	→	☐☐ hours/week
☐	☐	Other, list one task per line:		
	↳	1. ☐	→	☐☐ hours/week
		2. ☐	→	☐☐ hours/week
		3. ☐	→	☐☐ hours/week

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

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

Teen-LABS (BB) Behavior 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: ☒

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 →

↓ *Skip to question 2*

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

☐☐☐ lbs (or) ☐ *"no amount specified"*

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 →

↓ *Skip to question 3*

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*?	☐	☐
b. high protein/low carbohydrate (e.g., Atkins)?	☐	☐
c. ground or pureed foods?	☐	☐
d. other special diet not mentioned above? specify: ________	☐	☐

2.2 Did you follow the special diet?

☐ No ☐ Rarely ☐ Occasionally ☐ Usually ☐ Always

3. 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	Yes		
3.1 Lost weight	☐	☐	→	a. How much? ☐ lbs b. Were you purposefully trying to lose weight by eating less? ☐ No ☐ Yes
3.2 Gained weight	☐	☐	→	a. How much? ☐ lbs

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Teen-LABS (BB) Behavior Baseline

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

Teen-LABS (BB) Behavior Baseline

Continued from previous page

For weight control, have you ever...			**Did you do this in the 6 months prior to coming to this program?** No	Yes	How many weeks?
24. used laxatives for weight control?	☐ No	☐ Yes →	☐	☐ →	
25. used any prescription medication? *(e.g., Wellbutrin, Xenical, Medridia, Trexan, Ionamin, Adipex, Phentermine plus Fenfluramine, Topamax, Pondimin, Redux, Dexedrine)*	☐ No	☐ Yes →	☐	☐ →	
26. used any dietary supplement or non-prescription medication?	☐ No	☐ Yes →	☐	☐ →	

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 6 months 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?	☐ No	☐ Yes →	☐	☐	☐	☐	☐
2. seen a nutritionist/dietitian?	☐ No	☐ Yes →	☐	☐	☐	☐	☐
3. seen a personal trainer or exercise specialist?	☐ No	☐ Yes →	☐	☐	☐	☐	☐

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[3] 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

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

↓ *Skip to question 4*

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

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

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

Teen-LABS (BB) Behavior Baseline

This next set of questions[4] 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

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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[5] asks about alcohol use in the <u>past 12 months</u>.

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 **<u>past 12 months</u>**, 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 **<u>past 12 months</u>**, 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 **<u>past 12 months</u>**, 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 **<u>past 12 months</u>**, 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 **<u>past 12 months</u>**, 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

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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.)?	☐ No	☐ Yes
1.2 Amphetamines (such as white crosses, speed, "meth")?	☐ No	☐ Yes
1.3 Hallucinogens (such as LSD, mescaline)?	☐ No	☐ Yes
1.4 Inhalants (such as sniffing glue)?	☐ No	☐ Yes
1.5 Marijuana/hashish/pot?	☐ No	☐ Yes
1.6 Cocaine/crack?	☐ No	☐ Yes
1.7 PCP/Angel dust?	☐ No	☐ Yes

Acknowledgement of the following sources for questions contained on this form:

1. 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: ☐☐☐ Subject ID: ☐☐☐☐☐ Reviewed by (certification no.): ☐☐☐☐

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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 →

↓

Skip to question 2

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

___ lbs (or) ☐ *"no amount specified"*

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 →

↓

Skip to question 3

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*?	☐	☐
b. high protein/low carbohydrate (e.g., Atkins)?	☐	☐
c. ground or pureed foods?	☐	☐
d. other special diet not mentioned above?	☐	☐

specify: _____

2.2 Did you follow the special diet?

☐ No ☐ Rarely ☐ Occasionally ☐ Usually ☐ Always

3. 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	Yes		
3.1 Lost weight	☐	☐	→	a. How much? ___.___ lbs b. Were you purposefully trying to lose weight by eating less? ☐ No ☐ Yes
3.2 Gained weight	☐	☐	→	a. How much? ___.___ lbs

Site ID: ☐☐☐ Subject ID: ☐☐☐☐☐

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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.

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

Teen-LABS (BF) Behavior Follow-up

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: 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 dissatisifed 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[1] 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 satisifed nor dissatisfied →
- ☐ Somewhat dissatisfied →
- ☐ Dissatisfied →
- ☐ Very dissatisfied →

5.1 Why did you answer that way? *Mark "No" or "Yes" to each.*

No	Yes	
☐	☐	a. I have seen little or no benefit to my health
☐	☐	b. I am disappointed in the amount of weight I lost
☐	☐	c. I am disappointed in my appearance
☐	☐	d. I can no longer enjoy food
☐	☐	e. I can no longer eat with family or friends
☐	☐	f. I have had complications from the surgery
☐	☐	g. Other, specify:

Site ID: ☐☐☐ Subject ID: ☐☐☐☐☐

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Teen-LABS (BF) Behavior Follow-up

Directions: The following questions[2] 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?	☐ No	☐ Yes	→	
2. decreased fat intake?	☐ No	☐ Yes	→	
3. reduced the number of calories you eat?	☐ No	☐ Yes	→	
4. used a very low calorie diet?	☐ No	☐ Yes	→	
5. cut out between-meal-snacking?	☐ No	☐ Yes	→	
6. eaten fewer high carbohydrate foods like bread or potatoes?	☐ No	☐ Yes	→	
7. eaten special low calorie diet foods?	☐ No	☐ Yes	→	
8. eaten or drank meal replacements?	☐ No	☐ Yes	→	
9. increased fruits and vegetables?	☐ No	☐ Yes	→	
10. cut out non-diet soda pop or other sugar-sweetened beverages?	☐ No	☐ Yes	→	
11. chewed and spit out food?	☐ No	☐ Yes	→	
12. drank fewer alcoholic beverages for weight control?	☐ No	☐ Yes	→	
13. smoked cigarettes for weight control?	☐ No	☐ Yes	→	
14. induced vomiting for weight control?	☐ No	☐ Yes	→	
15. recorded what you eat daily?	☐ No	☐ Yes	→	
16. kept a graph of your weight?	☐ No	☐ Yes	→	
17. increased your exercise level?	☐ No	☐ Yes	→	
18. used home exercise equipment?	☐ No	☐ Yes	→	
19. recorded your exercise daily?	☐ No	☐ Yes	→	
20. participated in group exercise classes?	☐ No	☐ Yes	→	
21. participated in a support/self help group? *(e.g., Weight Watchers, TOPS)*	☐ No	☐ Yes	→	
22. accessed a discussion group, bulletin board, or chat room on the internet?	☐ No	☐ Yes	→	
23. used hypnosis for weight control?	☐ No	☐ Yes	→	
24. used laxatives for weight control?	☐ No	☐ Yes	→	
25. used any prescription medication? *(e.g., Wellbutrin, Xenical, Medridia, Trexan, Ionamin, Adipex, Phentermine plus Fenfluramine, Topamax, Pondimin, Redux, Dexedrine)*	☐ No	☐ Yes	→	
26. used any dietary supplement or non-prescription medication?	☐ No	☐ Yes	→	

Site ID: ☐☐☐ Subject ID: ☐☐☐☐☐

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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 past 6 months have you...				**How many times in the past 6 months?**			
				1 to 5 times	6 to 10 times	11 to 20 times	more than 20 times
1. seen a counselor/mental health professional?	☐ No	☐ Yes	→	☐	☐	☐	☐
2. seen a nutritionist/dietitian?	☐ No	☐ Yes	→	☐	☐	☐	☐
3. seen a personal trainer or exercise specialist?	☐ No	☐ Yes	→	☐	☐	☐	☐

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[3] 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

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

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 →

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

↓ *Skip to question 3*

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 →

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

↓ *Skip to question 4*

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 →

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

↓ *Skip to question 5*

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 →

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

↓ *Skip to question 6*

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 →

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

↓ *Skip to question 7 on page 6*

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 →

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

↓ *Skip to question 8*

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[4] 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

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

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

Teen-LABS (BF) Behavior Follow-up

The next set of questions[5] asks about alcohol use in the <u>past 12 months</u>.

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 **<u>past 12 months</u>**, 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 **<u>past 12 months</u>**, 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 **<u>past 12 months</u>**, 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 **<u>past 12 months</u>**, 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 **<u>past 12 months</u>**, 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.)?	☐ No	☐ Yes
1.2 Amphetamines (such as white crosses, speed, "meth")?	☐ No	☐ Yes
1.3 Hallucinogens (such as LSD, mescaline)?	☐ No	☐ Yes
1.4 Inhalants (such as sniffing glue)?	☐ No	☐ Yes
1.5 Marijuana/hashish/pot?	☐ No	☐ Yes
1.6 Cocaine/crack?	☐ No	☐ Yes
1.7 PCP/Angel dust?	☐ No	☐ 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: ☐☐☐ Subject ID: ☐☐☐☐☐ Reviewed by (certification no.): ☐☐☐☐

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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. **Vigorous activitie**s, such as running, lifting heavy objects, participating in strenuous sports	☐	☐	☐
4. **Moderate activitie**s, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf.	☐	☐	☐
5. Lifting or carrying groceries	☐	☐	☐
6. Climbing **several** flights of stairs	☐	☐	☐
7. Climbing **one** flight of stairs	☐	☐	☐
8. Bending, kneeling, or stooping	☐	☐	☐
9. Walking **more than a mile**	☐	☐	☐
10. Walking **several blocks**	☐	☐	☐
11. Walking **one block**	☐	☐	☐
12. Bathing or dressing yourself	☐	☐	☐

Ware JE, Kosinski M, Gandek B. *SF-36® Health Survey: Manual & Interpretation Guide.* Lincoln, RI: QualityMetric Incorporated, 1993, 2000.

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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 **amount of time** you spent on work or other activities	☐	☐
14. **Accomplished less** than you would like	☐	☐
15. Were limited in the kind of work or other activities	☐	☐
16. Had difficulty performing the work or other activities (for example, it took extra effort)	☐	☐

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 **amount of time** you spent on work or other activities	☐	☐
18. **Accomplished less** than you would like	☐	☐
19. Did work or other activities less carefully than usual	☐	☐

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

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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 **past 4 weeks**...	**All of the time**	**Most of the time**	**A good bit of the time**	**Some of the time**	**A little of the time**	**None of the time**
23. Did you feel full of pep?	☐	☐	☐	☐	☐	☐
24. Have you been a very nervous person?	☐	☐	☐	☐	☐	☐
25. Have you felt so down in the dumps that nothing could cheer you up?	☐	☐	☐	☐	☐	☐
26. Have you felt calm and peaceful?	☐	☐	☐	☐	☐	☐
27. Did you have a lot of energy?	☐	☐	☐	☐	☐	☐
28. Have you felt downhearted and blue?	☐	☐	☐	☐	☐	☐
29. Did you feel worn out?	☐	☐	☐	☐	☐	☐
30. Have you been a happy person?	☐	☐	☐	☐	☐	☐
31. Did you feel tired?	☐	☐	☐	☐	☐	☐

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.	☐	☐	☐	☐	☐
34. I am as healthy as anybody I know.	☐	☐	☐	☐	☐
35. I expect my health to get worse.	☐	☐	☐	☐	☐
36. My health is excellent.	☐	☐	☐	☐	☐

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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.

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Teen-LABS (PETSB)

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. 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.)*

No	Yes		No	Yes	
☐	☐	a. Depression	☐	☐	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:

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.)*

No	Yes		No	Yes	
☐	☐	a. Depression	☐	☐	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:

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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		No	Yes	
☐	☐	a. Depression	☐	☐	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		No	Yes	
☐	☐	a. Depression	☐	☐	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. Have you **ever** taken any medications for psychiatric or emotional problems?

☐ No ☐ Yes

↓

	Have you **ever** taken...		***if ever***	Are you **currently** taking...	
3.1 Antidepressants *(e.g., Prozac, Zoloft, Paxil)*	☐ No	☐ Yes	→	☐ No	☐ Yes
3.2 Major tranquilizers *(e.g., Risperdal, Zyprexa)*	☐ No	☐ Yes	→	☐ No	☐ Yes
3.3 Minor tranquilizers *(e.g., Ativan, Xanax)*	☐ No	☐ Yes	→	☐ No	☐ Yes
3.4 Mood stabilizers *(e.g., Lithobid, Tegretol, Topamax)*	☐ No	☐ Yes	→	☐ No	☐ Yes
3.5 Stimulants *(e.g., Ritalin, methylin)*	☐ No	☐ Yes	→	☐ No	☐ Yes
3.6 Other medication, specify:	☐ No	☐ Yes	→	☐ No	☐ Yes

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')*

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Teen-LABS (PETSF)

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. 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.)*

No	Yes		No	Yes	
☐	☐	a. Depression	☐	☐	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:

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.)*

No	Yes		No	Yes	
☐	☐	a. Depression	☐	☐	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:

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Teen-LABS (PETSF)

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		No	Yes	
☐	☐	a. Depression	☐	☐	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		No	Yes	
☐	☐	a. Depression	☐	☐	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 **ever** taken...		***if ever***	Are you **currently** taking...	
3.1 Antidepressants *(e.g., Prozac, Zoloft, Paxil)*	☐ No	☐ Yes	→	☐ No	☐ Yes
3.2 Major tranquilizers *(e.g., Risperdal, Zyprexa)*	☐ No	☐ Yes	→	☐ No	☐ Yes
3.3 Minor tranquilizers *(e.g., Ativan, Xanax)*	☐ No	☐ Yes	→	☐ No	☐ Yes
3.4 Mood stabilizers *(e.g., Lithobid, Tegretol, Topamax)*	☐ No	☐ Yes	→	☐ No	☐ Yes
3.5 Stimulants *(e.g., Ritalin, methylin)*	☐ No	☐ Yes	→	☐ No	☐ Yes
3.6 Other medication, specify:	☐ No	☐ Yes	→	☐ No	☐ Yes

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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.

Physical Comfort	**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**

Body Esteem	**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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Teen-LABS (IWQOL)

Social Life	**ALWAYS TRUE**	**USUALLY TRUE**	**SOMETIMES TRUE**	**RARELY TRUE**	**NEVER TRUE**
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**

Family Relations	**ALWAYS TRUE**	**USUALLY TRUE**	**SOMETIMES TRUE**	**RARELY TRUE**	**NEVER TRUE**
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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Teen-LABS (GSRS) Gastrointestinal Symptoms Rating Scale

Form completion date: ___ / ___ / 20___ *(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.

No discomfort at all (1)	Minor discomfort (2)	Mild discomfort (3)	Moderate discomfort (4)	Moderately severe discomfort (5)	Severe discomfort (6)	Very severe discomfort (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.)

Revicki DA, Wood M, Wiklund I, Crawley J. Reliability and validity of the gastrointestinal symptom rating scale in patients with gastroesophageal reflux disease. *Quality of Life Research.* v7, 1998.

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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

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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): ____

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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

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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: ___ / ___ / 20__ *(mm/dd/yyyy)*

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

1. Do you snore?
   - ☐ No → *skip to question 6*
   - ☐ Yes
   - ☐ Don't know → *skip to question 6*

2. Is your snoring:
   - ☐ Slightly louder than breathing
   - ☐ As loud as talking
   - ☐ Louder than talking
   - ☐ Very loud. Can be heard in adjacent rooms.
   - ☐ Don't know

3. How often do you snore?
   - ☐ 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
   - ☐ Don't know

4. Has your snoring ever bothered other people?
   - ☐ No
   - ☐ Yes

5. Has anyone noticed that you quit breathing during your sleep?
   - ☐ 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

6. How often do you feel tired or fatigued after your sleep?
   - ☐ 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

7. During your wake time, do you feel tired, fatigued or not up to par?
   - ☐ 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

8. Have you ever nodded off or fallen asleep while driving a vehicle?
   - ☐ N/A, I do not drive.
   - ☐ No
   - ☐ Yes →

   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

Netzer NC, Stoohs RA, Netzer CM, Clark K, Strohl KP. Using the Berlin Questionnaire to identify patients at risk for sleep apnea syndrome. Ann Int Med 131: 485-491, 1999.

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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*

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 question10.***

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

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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.

		fertility med used?		*Please mark **one** outcome per pregnancy*			
	your age	No	Yes	live birth	still birth	miscarriage	other outcome
Preg. 1	___	☐	☐	☐	☐	☐	☐
Preg. 2	___	☐	☐	☐	☐	☐	☐
Preg. 3	___	☐	☐	☐	☐	☐	☐
Preg. 4	___	☐	☐	☐	☐	☐	☐
Preg. 5	___	☐	☐	☐	☐	☐	☐
Preg. 6	___	☐	☐	☐	☐	☐	☐
Preg. 7	___	☐	☐	☐	☐	☐	☐
Preg. 8	___	☐	☐	☐	☐	☐	☐

☐ I have had more than 8 pregnancies

Teen-LABS (RHB) Reproductive Health Baseline

18. In the <u>past 12 months</u>, 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 **<u>past 12 months</u>**, 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 <u>past 12 months</u>. *(Mark "No" or "Yes" for each item.)*

No	Yes		No	Yes	
☐	☐	Pills, monthly (including one week of placebo or no pills, get period)	☐	☐	Diaphragm
☐	☐	Pills, continuous use (new pack every 3 weeks, no period)	☐	☐	Cervical cap
☐	☐	Mini Pill, continuous use (progestin only, get period)	☐	☐	Male or female condom
☐	☐	Patch or ring	☐	☐	Contraceptive foams, creams, jellies
☐	☐	Injections of medications (shots) or implantation of a medication release device	☐	☐	Natural family planning, rhythm method or having sex during "safe" times
☐	☐	IUD *If yes, specify:* ☐ Mirena ☐ Copper ☐ Don't know	☐	☐	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

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Teen-LABS (RHF) Reproductive Health Follow-up

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. **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*

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)

    If you marked one of these choices, you are done with this questionnaire. Please do not answer the remainder of this questionnaire.

    ☐ Birth control or other medication
    ☐ Chemotherapy
    ☐ Chronic illness
    ☐ Prolactin, adrenal gland or thyroid problem
    ☐ Pregnancy
    ☐ Breast feeding
    ☐ 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

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:

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

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

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

Teen-LABS (MAB) Medical Assessment 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: ☒

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.)*	No	Yes
1.1 your back, such as disc surgery, laminectomy, or fusion surgery?	☐	☐
1.2 your hip(s), such as joint replacement, reconstructive or arthroscopic surgery?	☐	☐
1.3 your knee(s), such as joint replacement, reconstructive or arthroscopic surgery?	☐	☐
1.4 your ankle(s), such as joint replacement, reconstructive or arthroscopic surgery?	☐	☐

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:	☐	☐	☐	☐	☐
b. Leg pain:	☐	☐	☐	☐	☐

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
☐	☐	☐	☐	☐	☐	☐

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
DRESSING & GROOMING				
Are you able to:				
1. Dress yourself, including tying shoelaces and doing buttons?	☐	☐	☐	☐
2. Shampoo your hair?	☐	☐	☐	☐
ARISING				
Are you able to:				
1. Stand up from a straight chair?	☐	☐	☐	☐
2. Get in and out of bed?	☐	☐	☐	☐
EATING				
Are you able to:				
1. Cut your meat?	☐	☐	☐	☐
2. Lift a full cup or glass to your mouth?	☐	☐	☐	☐
3. Open a new milk carton?	☐	☐	☐	☐
WALKING				
Are you able to:				
1. Walk outdoors on a flat ground?	☐	☐	☐	☐
2. Climb up five steps?	☐	☐	☐	☐

3B. Please mark any AIDS OR DEVICES that you usually use for any of these activities (*mark all that apply*):

☐ Cane
☐ Walker
☐ Crutches
☐ Wheelchair
☐ Devices used for dressing (button hook, zipper pull, long-handled shoe horn, etc.)
☐ Built up or special utensils
☐ Special or built up chair
☐ 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

Item 3 source: Health Assessment Questionnaire copyright Stanford University

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
HYGIENE				
Are you able to:				
1. Wash and dry your body?	☐	☐	☐	☐
2. Take a tub bath?	☐	☐	☐	☐
3. Get on and off the toilet?	☐	☐	☐	☐
REACH				
Are you able to:				
1. Reach and get down a 5-pound object (such as a bag of sugar) from just above your head?	☐	☐	☐	☐
2. Bend down to pick up clothing from the floor?	☐	☐	☐	☐
GRIP				
Are you able to:				
1. Open car doors?	☐	☐	☐	☐
2. Open jars which have been previously opened?	☐	☐	☐	☐
3. Turn faucets on and off?	☐	☐	☐	☐
ACTIVITIES				
Are you able to:				
1. Run errands and shop?	☐	☐	☐	☐
2. Get in and out of a car?	☐	☐	☐	☐
3. Do chores such as vacuuming or yardwork?	☐	☐	☐	☐

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

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	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10	SEVERE PAIN

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	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10	SEVERE PAIN

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	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10	SEVERE PAIN

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	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10	SEVERE PAIN

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	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10	SEVERE PAIN

Teen-LABS (MAB) Medical Assessment Baseline

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)*

	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	☐	☐	→	☐	☐	☐	☐
b. A walker	☐	☐	→	☐	☐	☐	☐
c. A cane	☐	☐	→	☐	☐	☐	☐

5. Have you **ever** had surgery for acid reflux, heartburn, or a hiatal hernia?

☐ No ☐ Yes

6. Have you **ever** 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. 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 ☐ Yes

8. 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 ☐ Yes

9. 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 ☐ Yes

↓

Skip to question 10

Teen-LABS (MAB) Medical Assessment Baseline

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)*
☐	☐	☐	☐

11. Have you ever 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

12. Have you ever had a kidney stone?

☐ No ☐ Yes

Teen-LABS (MAB) Medical Assessment Baseline

13. Have you experienced low blood sugar in the **past 3 months**?

☐ Don't know → *Skip to question 14*

☐ No → *Skip to 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 surgars 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 episoode of low blood sugar? *(Mark "Yes" or "No" for each.)*

No	Yes		No	Yes	
☐	☐	a. Hunger	☐	☐	f. Dizziness
☐	☐	b. Anxiousness	☐	☐	g. Trouble concentrating
☐	☐	c. Sweating	☐	☐	h. Trouble remembering words
☐	☐	d. Heart pounding	☐	☐	i. Blackouts
☐	☐	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.

Teen-LABS (MAB) Medical Assessment Baseline

14. Do you **currently** have diabetes?

☐ No ☐ Yes

↓ ↓

Skip to question 15

14.1 How long have you had diabetes? ☐☐ years and/or ☐☐ months

14.2 Are you **currently** taking medications for diabetes? *(Mark "No" or "Yes" for each.)*

	No	Yes	*If Yes,*		
a. Oral diabetes medication	☐	☐	→	14.2.1 How many years have you been taking oral diabetes medication?	☐☐ years and/or ☐☐ months
b. Insulin	☐	☐	→	14.2.2 How many total units of insulin do you currently inject each day?	☐☐☐ units/day
				14.2.3 How many total years have you been taking injections (insulin and/or non-insulin) for diabetes?	☐☐ years and/or ☐☐ months
c. Non-insulin injectable *(e.g., Byetta (exenatide) or Symlin (pramlintide))*	☐	☐	→	14.2.4 How many total units of non-insulin do you currently inject each day?	☐☐☐ units/day
				14.2.5 How many total years have you been taking injections (insulin and/or non-insulin) for diabetes?	☐☐ years and/or ☐☐ 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	☐	☐	→	☐	☐
b. Ketoacidosis	☐	☐	→	☐	☐
c. Severe skin infection (cellulitis)	☐	☐	→	☐	☐
d. Low blood flow to the toes, foot, or leg (claudication)	☐	☐	→	☐	☐
e. Amputation of the toes, foot, or leg	☐	☐	→	☐	☐
f. Nausea and vomiting due to gastroparesis	☐	☐	→	☐	☐
g. Kidney failure or other kidney complication	☐	☐	→	☐	☐
h. Other, specify:	☐	☐	→	☐	☐

Teen-LABS (MAB) Medical Assessment Baseline

15. **In the last 12 months**, have you been treated for a nutritional deficiency?

☐ No ☐ Yes → 15.1 Which nutrients? *(Mark "No" or "Yes" to each.)*

Skip to question 16

No	Yes		No	Yes	
☐	☐	a. Multi-Vitamin	☐	☐	h. Folate (Folic Acid)
☐	☐	b. Vitamin A	☐	☐	i. Iron (Ferrous sulfate)
☐	☐	c. Vitamin B12	☐	☐	j. Calcium
☐	☐	d. Vitamin D	☐	☐	k. Other 1, specify: _____
☐	☐	e. Thiamin (Vitamin B1)	☐	☐	l. Other 2, specify: _____
☐	☐	f. Potassium	☐	☐	m. Other 3, specify: _____
☐	☐	g. Magnesium			

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.

	No	Yes
20.1 Are your legs and/or feet numb?	☐	☐
20.2 Do you ever have any burning pain in your legs and/or feet?	☐	☐
20.3 Are your feet too sensitive to touch?	☐	☐
20.4 Do you get muscle cramps in your legs and/or feet?	☐	☐
20.5 Do you ever have any prickling feelings in your legs or feet?	☐	☐
20.6 Does it hurt when the bed covers touch your skin?	☐	☐
20.7 When you get into the tub or shower, are you able to tell hot water from the cold water?	☐	☐
20.8 Have you ever had an open sore on your foot?	☐	☐
20.9 Has your doctor ever told you that you have diabetic neuropathy?	☐	☐
20.10 Do you feel weak all over most of the time?	☐	☐
20.11 Are your symptoms worse at night?	☐	☐
20.12 Do your legs hurt when you walk?	☐	☐
20.13 Are you able to sense your feet when you walk?	☐	☐
20.14 Is the skin on your feet so dry that it cracks open?	☐	☐
20.15 Have you ever had an amputation?	☐	☐

Source: Michigan Diabetes Research and Training Center, www.med.umich.edu/mdrtc/survey/index.htm.

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

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Teen-LABS (MAF) Medical Assessment Follow-up

Form completion date: ☐☐ / ☐☐ / 20☐☐ *(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?	☐	☐
1.2 your hip(s), such as joint replacement, reconstructive or arthroscopic surgery?	☐	☐
1.3 your knee(s), such as joint replacement, reconstructive or arthroscopic surgery?	☐	☐
1.4 your ankle(s), such as joint replacement, reconstructive or arthroscopic surgery?	☐	☐

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:	☐	☐	☐	☐	☐
b. Leg pain:	☐	☐	☐	☐	☐

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
☐	☐	☐	☐	☐	☐	☐

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)*

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
DRESSING & GROOMING				
Are you able to:				
1. Dress yourself, including tying shoelaces and doing buttons?	☐	☐	☐	☐
2. Shampoo your hair?	☐	☐	☐	☐
ARISING				
Are you able to:				
1. Stand up from a straight chair?	☐	☐	☐	☐
2. Get in and out of bed?	☐	☐	☐	☐
EATING				
Are you able to:				
1. Cut your meat?	☐	☐	☐	☐
2. Lift a full cup or glass to your mouth?	☐	☐	☐	☐
3. Open a new milk carton?	☐	☐	☐	☐
WALKING				
Are you able to:				
1. Walk outdoors on a flat ground?	☐	☐	☐	☐
2. Climb up five steps?	☐	☐	☐	☐

3B. Please mark any AIDS OR DEVICES that you usually use for any of these activities (*mark all that apply*):

☐ Cane
☐ Walker
☐ Crutches
☐ Wheelchair
☐ Devices used for dressing (button hook, zipper pull, long-handled shoe horn, etc.)
☐ Built up or special utensils
☐ Special or built up chair
☐ 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

Item 3 source: Health Assessment Questionnaire copyright Stanford University

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
HYGIENE				
Are you able to:				
1. Wash and dry your body?	☐	☐	☐	☐
2. Take a tub bath?	☐	☐	☐	☐
3. Get on and off the toilet?	☐	☐	☐	☐
REACH				
Are you able to:				
1. Reach and get down a 5-pound object (such as a bag of sugar) from just above your head?	☐	☐	☐	☐
2. Bend down to pick up clothing from the floor?	☐	☐	☐	☐
GRIP				
Are you able to:				
1. Open car doors?	☐	☐	☐	☐
2. Open jars which have been previously opened?	☐	☐	☐	☐
3. Turn faucets on and off?	☐	☐	☐	☐
ACTIVITIES				
Are you able to:				
1. Run errands and shop?	☐	☐	☐	☐
2. Get in and out of a car?	☐	☐	☐	☐
3. Do chores such as vacuuming or yardwork?	☐	☐	☐	☐

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

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	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10	SEVERE PAIN

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	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10	SEVERE PAIN

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	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10	SEVERE PAIN

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	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10	SEVERE PAIN

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	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10	SEVERE PAIN

Site ID: ☐☐☐ Subject ID: ☐☐☐☐☐

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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)*

	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	☐	☐	→	☐	☐	☐	☐
b. A walker	☐	☐	→	☐	☐	☐	☐
c. A cane	☐	☐	→	☐	☐	☐	☐

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)*
☐	☐	☐	☐

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

12. ***Since your last study visit***, have you had a kidney stone?

☐ No ☐ Yes

Teen-LABS (MAF) Medical Assessment Follow-up

13. Have you experienced low blood sugar in the **past 3 months**?

☐ Don't know → *Skip to question 14*

☐ No → *Skip to 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 surgars 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 episoode of low blood sugar? *(Mark "Yes" or "No" for each.)*

No	Yes		No	Yes	
☐	☐	a. Hunger	☐	☐	f. Dizziness
☐	☐	b. Anxiousness	☐	☐	g. Trouble concentrating
☐	☐	c. Sweating	☐	☐	h. Trouble remembering words
☐	☐	d. Heart pounding	☐	☐	i. Blackouts
☐	☐	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.

Teen-LABS (MAF) Medical Assessment Follow-up

14. Do you **currently** have diabetes?

☐ No ☐ Yes

↓ ↓

Skip to question 15

14.1 Are you **currently** taking medications for diabetes? *(Mark "No" or "Yes" for each.)*

	No	Yes		
a. Oral diabetes medication	☐	☐		
			If Yes,	
b. Insulin	☐	☐	→ 14.1.1 How many total units of insulin do you currently inject each day?	☐☐☐ units/day
c. Non-insulin injectable *(e.g., Byetta (exenatide) or Symlin (pramlintide))*	☐	☐	→ 14.1.2 How many total units of non-insulin do you currently inject each day?	☐☐☐ units/day

14.2 ***Since your last study visit,*** have you required hospitalization for treatment of a diabetes complication?

☐ No ☐ Yes

↓

14.2.1 During your hospitalization, were you treated for any of the following due to diabetes? *(Mark "No" or "Yes" to each.)*

	No	Yes
a. Very high blood sugar or coma	☐	☐
b. Ketoacidosis	☐	☐
c. Severe skin infection (cellulitis)	☐	☐
d. Low blood flow to the toes, foot, or leg (claudication)	☐	☐
e. Amputation of the toes, foot, or leg	☐	☐
f. Nausea and vomiting due to gastroparesis	☐	☐
g. Kidney failure or other kidney complication	☐	☐
h. Other, specify:	☐	☐

15. ***Since your last study visit,*** have you been treated for a nutritional deficiency?

☐ No ☐ Yes →

↓

Skip to question 16

15.1 Which nutrients? *(Mark "No" or "Yes" to each.)*

No	Yes		No	Yes	
☐	☐	a. Multi-Vitamin	☐	☐	h. Folate (Folic Acid)
☐	☐	b. Vitamin A	☐	☐	i. Iron (Ferrous sulfate)
☐	☐	c. Vitamin B12	☐	☐	j. Calcium
☐	☐	d. Vitamin D	☐	☐	k. Other 1, specify: _____
☐	☐	e. Thiamin (Vitamin B1)	☐	☐	l. Other 2, specify: _____
☐	☐	f. Potassium	☐	☐	m. Other 3, specify: _____
☐	☐	g. Magnesium			

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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 ☐ Yes

17. ***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 ☐ Better

18. ***Since your last study visit,*** have you experienced unusual hair loss to the point of being noticed by others or requiring a wig?

☐ No ☐ Yes

19. ***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?	☐	☐
20.2 Do you ever have any burning pain in your legs and/or feet?	☐	☐
20.3 Are your feet too sensitive to touch?	☐	☐
20.4 Do you get muscle cramps in your legs and/or feet?	☐	☐
20.5 Do you ever have any prickling feelings in your legs or feet?	☐	☐
20.6 Does it hurt when the bed covers touch your skin?	☐	☐
20.7 When you get into the tub or shower, are you able to tell hot water from the cold water?	☐	☐
20.8 Have you ever had an open sore on your foot?	☐	☐
20.9 Has your doctor ever told you that you have diabetic neuropathy?	☐	☐
20.10 Do you feel weak all over most of the time?	☐	☐
20.11 Are your symptoms worse at night?	☐	☐
20.12 Do your legs hurt when you walk?	☐	☐
20.13 Are you able to sense your feet when you walk?	☐	☐
20.14 Is the skin on your feet so dry that it cracks open?	☐	☐
20.15 Have you ever had an amputation?	☐	☐

Source: Michigan Diabetes Research and Training Center, 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 ☐ Yes

22. ***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

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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 medicaitons 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 **missed** taking that supplement/ vitamin in the **past week**.

How many times a day (not how many pills) does your physician **recommend** that you take the following supplements/vitamins? (If not at all, enter 0.)		Do you currently take this supplement/ vitamin? No	Yes	*If yes*	How many times do you think you have **missed** taking your supplements/ vitamins in the past week?
1. A multivitamin (pill, chewable, liquid, or spray)	___ times each day →	☐	☐	→	___ times missed
2. Calcium (pill, chewable, liquid, or powder)	___ times each day →	☐	☐	→	___ times missed
3. Vitamin D alone (pill, chewable, liquid, or powder)	___ times each day →	☐	☐	→	___ times missed
4. Iron (pill, chewable, or liquid)	___ times each day →	☐	☐	→	___ times missed
5. Vitamin B12 (pill, liquid, or spray)	___ times each day →	☐	☐	→	___ 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.

☐ Forgetting to take them or bring them with you
☐ Hard to swallow
☐ Inconvenient
☐ Embarrassed to take them
☐ Dosing schedules does not match my lifestyle
☐ Difficult to understand doctor's instructions about them
☐ They don't work
☐ Would rather do something else than take medications
☐ Too expensive
☐ I don't need them
☐ Side effects (e.g. nausea, stomach ache, constipation)

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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	☐	☐	→	___ days
10.2 Your hip(s)	☐	☐	→	___ days
10.3 Your knee(s)	☐	☐	→	___ days
10.4 Your ankle(s)	☐	☐	→	___ days

11. In the **past week**, have you taken any prescription or over-the-counter medication for acid relux, 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 asprin 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

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Teen-LABS (MED) Medications

13. Have you taken any medications that are NOT vitamin or mineral related in the **past 90 days** that can only be obtained with a prescription from your doctor?

☐ No ☐ Yes (Please bring your prescription medications to your next Teen LABS visit.)

↓

Please print the name (as listed on your medication bottle/container) of each prescription medication that you have taken in the **past 90 days**.

Medication Name	**How often do you take it?** **No longer taking**	**Daily** (1 or more times/day)	**Weekly** (1-6 times/wk)	**Monthly/ Rarely** (0-3 times/mon)	**As Needed**	***For Coordinator Use Only*** Verified by container?
	☐	☐	☐	☐	☐	☐ No ☐ Yes
	☐	☐	☐	☐	☐	☐ No ☐ Yes
	☐	☐	☐	☐	☐	☐ No ☐ Yes
	☐	☐	☐	☐	☐	☐ No ☐ Yes
	☐	☐	☐	☐	☐	☐ No ☐ Yes
	☐	☐	☐	☐	☐	☐ No ☐ Yes
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	☐	☐	☐	☐	☐	☐ No ☐ Yes
	☐	☐	☐	☐	☐	☐ No ☐ Yes
	☐	☐	☐	☐	☐	☐ No ☐ Yes

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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.

	Yes	No	Don't know
1. While sleeping, does your child...			
a. snore more than half the time?	☐	☐	☐
b. always snore?	☐	☐	☐
c. snore loudly?	☐	☐	☐
d. have 'heavy' or loud breathing?	☐	☐	☐
e. have trouble breathing or struggle to breathe?	☐	☐	☐
2. Have you ever seen your child stop breathing during the night?	☐	☐	☐
3. Does your child...			
a. tend to breathe through the mouth during the day?	☐	☐	☐
b. have a dry mouth on waking up in the morning?	☐	☐	☐
c. occasionally wet the bed?	☐	☐	☐
d. wake up feeling unrefreshed in the morning?	☐	☐	☐
e. have a problem with sleepiness during the day?	☐	☐	☐
4. Has a teacher or other supervisor commented that your child appears sleepy during the day?	☐	☐	☐
5. Is it hard to wake your child up in the morning?	☐	☐	☐
6. Does your child wake up with headaches in the morning?	☐	☐	☐
7. Did your child stop growing at a normal rate at any time since birth?	☐	☐	☐
8. This child often...			
a. does not seem to listen when spoken to directly.	☐	☐	☐
b. has difficulty organizing task and activities.	☐	☐	☐
c. is easily distracted by extraneous stimuli.	☐	☐	☐
d. fidgets with hands or feet or squirms in seat.	☐	☐	☐
e. is 'on the go' or often acts as if 'driven by a motor.'	☐	☐	☐
f. interrupts or intrudes on others (e.g., butts into conversations or games).	☐	☐	☐

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Teen-LABS (WHQ) Weight History Questionnaire

Form completion date: ___ / ___ / 2 0___ *(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: ___ ft ___ in	How sure of answer: 100%	90	80	70	60	50	40	30	20	10	0%
Weight at 13 years: ___ 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: ___ ft ___ in	How sure of answer: 100%	90	80	70	60	50	40	30	20	10	0%
Weight at 18 years: ___ 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: ___ **age** **grade** *(circle which)*	How sure of answer: 100%	90	80	70	60	50	40	30	20	10	0%

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: ___	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: ___,___	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: ___,___	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: ___,___	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 <u>WEIGHT</u>:

	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	☐	☐ ↳	☐ ↳	___,___ **age grade** *(circle which)*
I was unable to walk up several flights of stairs	☐	☐ ↳	☐ ↳	___,___ **age grade** *(circle which)*
I could not participate in sports or other physically difficult activities	☐	☐ ↳	☐ ↳	___,___ **age grade** *(circle which)*
My clothes came from a special section or store for larger people	☐	☐ ↳	☐ ↳	___,___ **age grade** *(circle which)*

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

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Teen-LABS (IPAQ) International Physical Activity Questionnaire

Date form administered: ☐☐ / ☐☐ / 2 0 ☐☐ *(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***

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**

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**

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**

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**

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

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Teen-LABS (IPS) International Prevalence Study on Physical Activity

Date form administered: ☐☐ / ☐☐ / 2 0 ☐☐ *(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

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

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

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