Entered:/_	_/20	Initials:	Verified:/	/20	Initi	als:	
Patient ID			fice use only.		Visi	Visit: 1	
			(BB) - Version: 06/15/	2006			
Form Completio	n Date mm		gg) versioni vo/10/	2000			
Directions: Pl	ease complete	e the following questions by	checking the appropria	nte response o	or filling in th	e blank.	
1. Were you ado		red by your doctor or other	health care provider to	lose weight p	orior to your		
□ 0. No	□ 1. Yes						
Skip to question 2	1.1 How n	nuch weight were you advis	ed or required to lose?				
		fied"					
2. Were you advaurgery?	vised or requi	red by your doctor or other	health care provider to	start a specia	l diet prior to	your obesity	
□ 0. No	□ 1. Yes <u> </u>						
Skip to question 3		is special diet "no" or "yes" for each)		No	Yes		
	using	low calorie (less than 800 c a commercial weight loss p ttrifast, or eating smaller po	product like Optifast				
	b. high	protein/low carbohydrate (i	.e. Atkins)?				
	c. groun	nd or pureed foods?					
		r special diet not mentioned rify:					
	2.2 Did yo	u follow the special diet?	<ul><li>□ 1. No</li><li>□ 2. Rarely</li><li>□ 3. Occasionally</li></ul>	□ 4. Ust □ 5. Alv	•		
3. Have you los	t or gained an	y weight in the <b>past 3 mon</b>	ths (check yes or no to	each)?			
□ □ Lost w	reight →	a. How much? ll	os.				
		b. Were you purposefull	y trying to lose weight l	by eating less	s? □ 0. N	o □ 1. Yes	
	l weight →	a. How much? 1	bs.				
□ □ No ch	ange in weigh	nt					
□ □ Don't	know						

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

1.	The first weight is your <u>dream weight</u> ,	, a	weight that	you would	choose if
	you could weigh whatever you wanted	1.	What is this	s 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 be not 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?

□ 0. No	☐ 1. Yes		
$\downarrow$	<b>↓</b>		
Skip to next question on	1.1 How o	ften do you weigh yourself (check	one answer only)?
next page		□ 1. Never	$\square$ 5. Ever
		$\square$ 2. About once a year or less	□ 6. Ever

☐ 6. Every day

☐ 5. Every week

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

• If you ever did an activity in order to control your weight, check "yes" and follow the arrow to complete the next column indicating whether you did the activity in the **past 6 months** to control your weight and if so, **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 never did an activity in order to control your weight, check "no" and go to the next item.

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

Patient ID		_			_	

Continued from previous page

For weight control, have you ever	Did you do this in the past 6 months?				
			No	Yes	How many weeks?
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 nonprescription 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**.

- If you ever saw one of the professionals listed below in order to control your weight, check "yes" and follow the arrow to complete the next column indicating **how many times** you saw the professional in the **past 6 months**.
- If you **never** saw the professional in order to control your weight, check "no" and go to the next item.

For weight control, have you ever	How many times in the past 6 months?					
		0 times	1 to 5 times	6 to 10 times	11 to 20 times	more than 20 times
seen a counselor/mental health professional?	$\square$ No $\square$ Yes $\rightarrow$					
2. seen a nutritionist/dietitian?	$\square$ No $\square$ Yes $\rightarrow$					
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 <b>7-day week</b> do you e	days/wk					
	b. How many days out of the <b>7-day week</b> do you e	days/wk	days/wk				
	c. How many days out of the 7-day week do you e	days/wk	days/wk				
	d. Counting all meals and any snacks you may hav a day do you eat? (check box if more than 10 tin	times/day	10 times a day				
2.	How many days a week do you eat out at	<u>Breakfast</u>	Brunch/lunch	<u>Dinner</u>			
	a. Fast food restaurants:	days/wk	days/wk	days/wk			
	b. Other types of restaurants:	days/wk	days/wk	days/wk			

					Patie	ent ID					
T	he next questio	n asks about your lij	felong eating habi	its.							
1.	Have you eve much you wo		u eat continuously	during the day or	parts of the	day without <sub>l</sub>	planning what and hov				
	□ 0. No	□ 0. No □ 1. Yes →  1.1 Did you experience a loss of control, that is you felt like you control your eating? □ □ 0. No □ 1. Yes									
T	he next questio	ns ask about your ed	uting habit <sup>3</sup> s over	the past 6 months	<u>s.</u>						
2.		st 6 months, have you and how much you		you eat continuo	ously during t	he day or par	ts of the day without				
	□ 0. No	□1 . Yes →	□1. Yes → Did you experience a loss of control, that is you felt control your eating? □0. No □1. Yes								
3.		est 6 months, did you ge amount of food?	ı ever eat within aı	ny two-hour perio	od what most	people would	d regard as an				
	□ 0. No ↓	□ 1. Yes									
<ul> <li>Skip to question 5</li> <li>3.1 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 is have been some weeks when it was not present – just average those in).</li> <li>□ 1. Less than one day a week</li> <li>□ 2. One day a week</li> <li>□ 5. Nearly every day</li> <li>□ 3. Two or three days a week</li> </ul>											
		3.2 Did you <b>usual</b>			ences during						
			ch more rapidly th				□ 1. Yes				
			il you felt uncomf		☐ 1. Yes						
		physically	rge amounts of food when you didn't feel $\Box$ 0. No $\Box$ 1. Yes y hungry.								
		_	ne because you we were eating.	□ 0. No	□ 1. Yes						
		_	Feeling disgusted with yourself, depressed, or $\Box$ 0. No $\Box$ feeling very guilty after overeating.								
4.	During the <b>pa</b> for you)?	st 6 months, when y	ou overate how up	oset were you from	n overeating	(eating more	than you think is best				
	1. Not at all	☐ 2. Slightl	y □ 3.	Moderately	□ 4. Gre	eatly	☐ 5. Extremely				
5.		ring the <b>past 6 mont</b> ou couldn't stop eatin					set were you by the				
	1. Not at all	☐ 2. Slightl	y □ 3.	Moderately	□ 4. Gre	eatly	☐ 5. Extremely				

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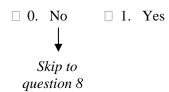
6. During the <u>past 6 months</u>, how important has your weight or shape been in how you feel about or evaluate yourself as a person – as compared to other aspects of your life, such as how you do at work, as a parent, or how you get along with other people?

 $\square$  1. Weight and shape were **not very important.** 

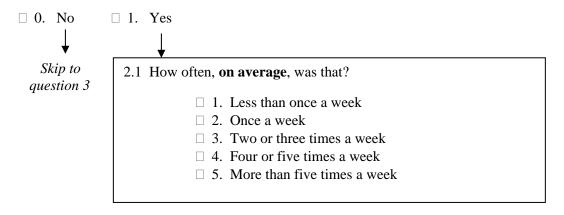
- $\square$  2. Weight and shape **played a part** in how I felt about myself.
- □ 3. Weight and shape **were among the main things** that affected how I felt about myself.
- □ 4. Weight and shape **were the most important things** that affected how I felt about myself.

### This next set of questions asks about activities related to binge eating over the past 3 months.

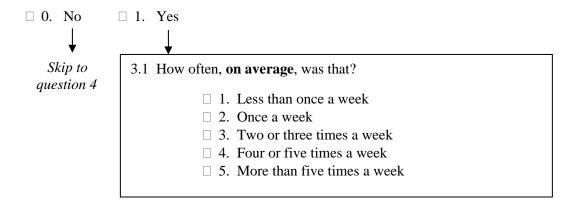
1. In the <u>past 3 months</u>, have you had any episodes of binge eating (consuming large amounts of food in a short period of time)?



2. During the **past 3 months**, did you ever make yourself vomit to avoid gaining weight after binge eating?

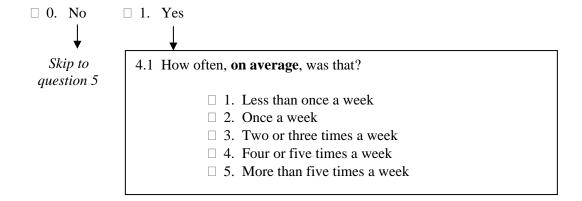


3. During the <u>past 3 months</u>, did you ever take more than twice the recommended dose of laxatives in order to avoid gaining weight after binge eating?

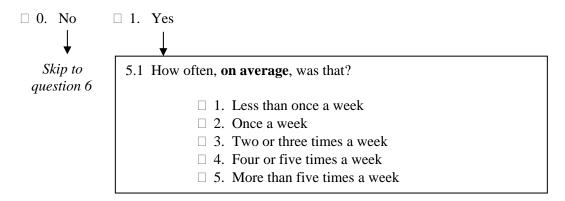


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Patient ID	 	 	 	 

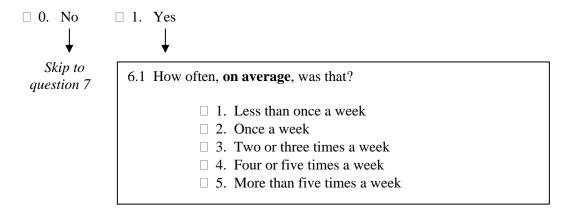
4. During the <u>past 3 months</u>, did you ever take more than twice the recommended dose of diuretics (water pills) in order to avoid gaining weight after binge eating?



5. During the **past 3 months**, did you ever fast (not eat anything at all for at least 24 hours) in order to avoid gaining weight after binge eating?



6. During the <u>past 3 months</u>, did you ever exercise for more than an hour **specifically** in order to avoid gaining weight after binge eating?



	the <b>past 3 months</b> , did you ever take more than twice the recommended dose of a diet pill in a avoid gaining weight after binge eating?
□ 0. 1	No □ 1. Yes ↓
-	7.1 How often, <b>on average</b> , was that?
que	□ 1. Less than once a week □ 2. Once a week □ 3. Two or three times a week □ 4. Four or five times a week □ 5. More than five times a week
8. During	the past 3 months, have you withheld your use of insulin to try to control your weight?
□ -2.	I do not use insulin $\Box$ 0. No $\Box$ 1. Yes
This next is past 3 mo	set of questions asks about how you have felt and how often you did various activitie <sup>4</sup> s in the o <u>nths</u> .
1. During	the past 3 months, how much of your daily food intake did you consume after suppertime?
	<ul> <li>□ 0. None</li> <li>□ 1. Up to a quarter</li> <li>□ 2. About half</li> <li>□ 3. More than half</li> <li>□ 4. Almost all</li> </ul>
2. During	the past 3 months, how hungry were you on a usual morning?
	$\square$ 0. Not at all $\square$ 1. A little $\square$ 2. Somewhat $\square$ 3. Moderately $\square$ 4. Very
3. During	the past 3 months, how often did you have trouble getting to sleep?
	$\square$ 0. Never $\square$ 1. Sometimes $\square$ 2. About half the time $\square$ 3. Usually $\square$ 4. Always
4. Other the night?	han to use the bathroom, during the <b>past 3 months</b> , how often did you get up at least once in the middle of the
6	<ul> <li>□ 0. Never → Skip to question 6</li> <li>□ 1. Less than once a week</li> <li>□ 2. About once a week</li> <li>□ 3. More than once a week</li> </ul>

Patient ID \_\_\_\_ - \_\_\_ - \_\_\_\_

☐ 4. Every night

5.	During the <u>past 3 months</u> , when you got up in the middle of the night, how often did you snack?
	$\Box$ 0. Never $\rightarrow$ Skip to question 6
	□ 1. Sometimes
	☐ 2. About half of the time
	□ 3. Usually
	□ 4. Always
	lack
	5.1 When you snacked in the middle of the night, how aware were you of your eating?
	□ 0. Not at all
	□ 1. A little
	☐ 2. Somewhat
	□ 3. Very much
	☐ 4. Completely
6.	During the <b>past 3 months</b> , were you in an occupation involving night or evening shifts or other unusual time requirements that interfere with meals?
	□ 0. No □ 1. Yes
7.	During the past 3 months, how often did you keep eating a meal even though you were not hungry any more?
	□ 0. Rarely or never
	☐ 1. Occasionally (once per week)
	☐ 2. Frequently (more than once per week)
	□ 3. Nearly every day
8.	During the <u>past 3 months</u> , how often did you keep eating a meal even though you felt full?
	$\Box$ 0. Rarely or never
	☐ 1. Occasionally (once per week)
	$\Box$ 2. Frequently (more than once per week)
	$\Box$ 3. Nearly every day
Th	is next set of questions asks about tobacco use.
1.	Do you currently smoke cigarettes? $\Box$ 0. No $\Box$ 1. Yes
	If yes,
	1.1 On average, how many packs per day do you currently smoke?packs/day

Patient ID \_\_\_\_ - \_\_\_ - \_\_\_\_

I K	us next set of questions as	sks about alconol use i	n the <u>past 12 month</u>	<u>is</u> ?	
1.	How often do you have a  □ 0. Never → Sk □ 1. Monthly or □ 2. Two to four □ 3. Two to three □ 4. Four or more	cip to next page less times a month e times per week	ol?		
2.	How many drinks contain	ning alcohol do you hav	e on a typical day w	hen you are drinking?	
	☐ 1 or 2 drinks	$\Box$ 3 or 4 drinks	□ 5 or 6 drinks	□ 7 to 9 drinks	□ 10 or more drinks
3.	How often do you have si	ix or more drinks on one	e occasion?		
	□ Never	☐ Less than monthly	□ Monthly	☐ 2 to 3 times/week	☐ 4 or more times a week
4.	How often, during the <b>pa</b> started?	st 12 months, have you	found that you wer	e not able to stop drinking	once you had
	□ Never	<ul><li>Less than monthly</li></ul>	☐ Monthly	□ 2 to 3 times/week	☐ 4 or more times a week
5.	How often, during the <b>pa</b> drinking?	st 12 months, have you	failed to do what w	as normally expected from	you because of
	□ Never	<ul><li>Less than monthly</li></ul>	□ Monthly	□ 2 to 3 times/week	☐ 4 or more times a week
6.	How often, during the <b>pa</b> heavy drinking session?	st 12 months, have you	needed a first drink	in the morning to get your	rself going after a
	□ Never	<ul><li>Less than monthly</li></ul>	☐ Monthly	□ 2 to 3 times/week	☐ 4 or more times a week
7.	How often, during the <b>pa</b>	st 12 months, have you	had a feeling of gui	ilt or remorse after drinking	g?
	□ Never □	1 or 2 times $\Box$ 3 or	r 4 times $\Box$ 5 or	6 times $\Box$ 7 to 9 times	$\Box$ 10 or more times
8.	How often, during the <b>pa</b> because you had been dri		been unable to rem	ember what happened the	night before
	□ Never	<ul><li>Less than monthly</li></ul>	☐ Monthly	☐ 2 to 3 times/week	☐ 4 or more times a week
9.	Have you or someone els	e been injured as a resul	It of your drinking?		
	□ No	☐ Yes, but not in	the last year	☐ Yes, during the pa	st 12 months
10	). Has a relative or friend, o you cut down?	or doctor or other health	worker been conce	rned about your drinking o	r suggested
	□ No	☐ Yes, but not in	the last year	☐ Yes, during the pa	st 12 months

Patient ID \_\_\_\_ - \_\_ - \_\_\_ - \_\_\_

	Patient ID	 
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.)?	□ 0. No	□ 1. Yes
1.2	Amphetamines (such as white crosses, speed, "meth")?	□ 0. No	□ 1. Yes
1.3	Hallucinogens (such as LSD, mescaline)?	□ 0. No	□ 1. Yes
1.4	Inhalants (such as sniffing glue)?	□ 0. No	□ 1. Yes
1.5	Marijuana/hashish/pot?	□ 0. No	□ 1. Yes
1.6	Cocaine/crack?	□ 0. No	□ 1. Yes
1.7	PCP/Angel dust?	□ 0. No	□ 1. Yes

LABS gratefully acknowledges the following sources for questions contained on this form:

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.

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<sup>&</sup>lt;sup>1</sup>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.

<sup>&</sup>lt;sup>2</sup> Look AHEAD Study and also based in part on the following sources:

<sup>&</sup>lt;sup>3</sup> QEWP-R© Spitzer RL, Yanovski SZ, Marcus MD. (HaPI Record). 1994; Pittsburgh PA: Behavioral Measurement Database Services (Producer). McLean, VA: BRS Search Service (Vendor).

<sup>&</sup>lt;sup>4</sup> Nighttime Eating Phone Screen, Dr. James Mitchell, Neuropsychiatric Research Institute, Fargo, ND.

<sup>&</sup>lt;sup>5</sup> 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

### **BEHAVIOR BASELINE (BB)**

### **PURPOSE:**

To collect behavior information on patients aged 18 years or older enrolled in LABS-1, who have provided informed consent for LABS-2, prior to bariatric surgery.

### PERSON(S) RESPONSIBLE: SOURCES OF INFORMATION:

Clinician/Coordinator Patient

## WHEN TO ADMINISTER FORM:

Once patient provides informed consent for LABS-2, prior to surgery. This form should be administered after the DIB. If it is being administered at the clinic visit it should be administered prior to the BDI, else it should be administered prior to the SF36.

This questionnaire should be completed at the baseline visit only. It can be sent to patient by mail for patient to complete at home and return to coordinator prior to bariatric surgery or it can be completed at the clinic visit. The coordinator or other study staff must review the document at patient's clinic visit to ensure that all fields have been completed appropriately.

# **GENERAL INSTRUCTIONS** (Patient)

This questionnaire is to be completed by the patient. If the patient is not able to complete the form without help, the coordinator or patient designee may read the questions and answers to the patient.

# **GENERAL INSTRUTIONS:** (Clinician)

Before the form is given/sent to the patient:

(1) Write the patient id on the form. Because this form is administered at baseline only the visit number has been preprinted on the form.

After patient completes survey:

- (1) Review the form for any missing items. Follow-up with patient if necessary to record missing items, or to clarify responses.
- (2) Make sure that each item has a single response marked, unless directions state otherwise.
- (3) If the patient does not understand the question, a coordinator or patient designee may read the question to them. Do not answer the question. Indicate whether the response is unknown or if the patient refused to provide an answer.

### **SCORING ALGORITHM:**

N/A

DATA SECTION	COMPLETE INSTRUCTIONS
PATIENT ID:	Record the patient's ID number. The ID number is assigned via the ID registration application of the MATRIX Web Data Management System (MATRIX). Instructions on using this application are included in the MATRIX Manual. The ID should be written on every page of the BID form prior to it being administered to the patient.  NOTE: The patient ID number is the same as that assigned to the patient as part of the LABS-1 study.
VISIT:	Because this form is only administered at the baseline time point, the visit number (1) has been pre-printed on the form.
FORM COMPLETION DATE:	Patient records the date of form completion (mm/dd/20yy)
WEIGHT LOSS BEFORE SURGERY:	<ol> <li>Patient records "No" or "Yes" if they were advised or required by their doctor or other health care provider to lose weight prior to surgery.</li> <li>1.1 If patient was not advised to lose weight: Patient may skip to question 2, regarding special diets.</li> <li>If patient was advised to lose weight prior to surgery: Patient must record how much weight (lbs.) they were required to lose. If no amount was specified, the patient should select the appropriate box.</li> <li>Patient records "No" or "Yes" if they were advised or required by their doctor or other health care provider to start a special diet prior to surgery.</li> <li>Specify the special diet: Patient must select "No" or "Yes" for each:         <ul> <li>a. Very low calorie – defined as less than 800</li> </ul> </li> </ol>
	calories.  b. High protein/low carbohydrate c. Ground or pureed foods d. Other special diet – Specify.  2.2 Record how often the special diet was followed: Patient must specify if they followed the special diet as advised.

DATA SECTION		COMPLETION INSTRUCTIONS
	3.	Patient records if they have lost or gained any weight in the <i>past 3 months</i> . Patient must select "no" or "yes" to each.
		If patient has <i>lost</i> weight: They must indicate:  a. Amount of weight lost (lbs.)  b. If they lost weight on purpose by eating less
		If patient gained weight: They must indicate: a. Amount of weight gained (lbs.)
GOALS AND RELATIVE WEIGHTS QUESTIONS:	1.	Patient records their <i>Dream Weight</i> (lbs.). Dream Weight is defined as a weight that the patient would choose if they could weigh whatever they wanted.
	2.	Patient records their <i>Happy Weight</i> (lbs.). Happy Weight is not as ideal as patient's dream weight, however it is a weight that they would be happy to achieve.
	3.	Patient records their <i>Acceptable Weight</i> (lbs.). Acceptable Weight is a weight that the patient would not be especially happy with, but that the patient would accept, since it would be less than their current weight.
	4.	Patient records their <i>Disappointed Weight</i> (lbs.). Disappointed Weight is a weight that the patient would not view as successful in any way. The patient would be disappointed if it was their final weight after surgery.
WEIGHT CONTROL PRACTICES:	1.	Patient records "No" or "Yes" if they have access to a scale to weigh themselves.
	1.1	If the patient <i>does not</i> have access to a scale: Patient may skip to question 1 in the next section.
		If the patient has access to a scale: Patient must select one of the following regarding frequency of use:  1. Never 5. Every week 2. About once a year or less 6. Every Day 3. Every couple months 7. More than once per day 4. Every month

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DATA SECTION	COMPLETION INSTRUCTIONS
For items 1-26: activities to control	Patient must indicate if they have <i>ever</i> participated in an
weight	activity in order to control their weight.
	If patient has participated in any of the weight control practices listed: Patient must answer whether or not they participated in that activity in the past 6 months, and if yes they must record the number of weeks in which they participated in that activity.
	If patient <i>never</i> participated in any of the activities listed: Patient should check "No" for that activity and skip to the next item
For items 1-3: seen any professionals to control weight	Patient must indicate if they have <i>ever</i> seen a professional in order to control their weight.
	If patient has seen a professional: Patient must answer how many times, in the past 6-months, a professional was seen.
	If patient never seen a professional: Patient should check "No" for that item and skip to the next item.
EATING HABITS:	<ol> <li>Patient records how many days over the past 7-day week that they ate:         <ol> <li>breakfast</li> <li>lunch/brunch</li> <li>dinner</li> <li>Patient records how many times a day that they eat. If patient eats more than 10 times a day, the box stating so should be selected.</li> </ol> </li> </ol>
	<ul> <li>Patient records number of times per week that they eat (Breakfast, Brunch/Lunch, Dinner) out at:</li> <li>a. Fast food restaurants</li> <li>b. Other types of restaurants</li> </ul>

DATA SECTION	Ī	COMPLETION INSTRUCTIONS
EATING BEYOND SATIATION:	1.	Patient records whether they have <i>ever in their lifetime</i> ate continuously during the day or parts of the day without planning what and how much they would eat.
		If patient has <i>never</i> ate continuously throughout the day as described: Patient should select "No" and skip to question 2.
		If patient has eaten continuously throughout the day as described: Patient must indicate "No" or "Yes" if they felt their continuous eating was out of their control.
	2.	Patient records whether they have <i>ever in the past 6 months</i> ate continuously during the day or parts of the day without planning what and how much they would eat.
		If patient has <i>never</i> ate continuously throughout the day as described: Patient should select "No" and skip to question 3.
		If patient has eaten continuously throughout the day as described: Patient must indicate "No" or "Yes" if they felt their continuous eating was out of their control.
	3.	Patient records whether they have <i>ever in the past 6 months</i> eaten within two hours, more than what most people would regard as an unusually large amount of food.
		If patient answers "No": Patient may skip to question 5.
		If patient answers "Yes": Patient must answer questions 3.1 and 3.2.
	3.1	Patient must record how many time they felt that they at large amounts of food, plus felt that their eating was out of their control.

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DATA SECTION		COMPLETION INSTRUCTIONS
	3.2	Patient must answer "No" or "Yes" for each statement regarding their usual experiences when they felt that they ate large amounts of food, plus that their eating was out of control.
	4.	Patient must indicate how upset they were by their overeating over the <i>past 6 months</i> .
	5.	Patient must indicate how upset they were by out of control eating over the <i>past 6 months</i> .
	6.	Patient must indicate importance of their weight or shape in relation to their self-worth as compared to other aspects of their life (work, parenting, and interpersonal relationships).
BINGE EATING:	1.	Patient must record "No" or "Yes" if they have experienced binge eating over the <i>past 3 months</i> .
		If patient answers "No": Patient may skip to question 8.
		If patient answers "Yes": Patient must answer question 2.
	2.	Patient must answer "No" or "Yes" if they have ever in the past 3 months made himself vomit to avoid gaining weight after binge eating.
		If the patient answers "No": Patient may skip to question 3.
	2.1	If the patient answers "Yes": Patient must indicate the number of times, on average the vomited to avoid gaining weight.
	3.	Patient must record "No" or "Yes" if they have ever <i>in the past 3 months</i> taken more that twice the recommended dose of laxatives to avoid gaining weight after binge eating.
		If patient answers "No": Patient may skip to question 4.

DATA SECTION		COMPLETION INSTRUCTIONS
		If patient answers "Yes": Patient must indicate the number of times in the past 3 months, on average they overused laxatives in order to avoid gaining weight after binge eating.
	4.	Patient must record "No" or "Yes" if they have ever in the past 3 months taken more that twice the recommended dose of diuretics to avoid gaining weight after binge eating.
		If patient answers "No": Patient may skip to question 5.
		<u>If patient answers "Yes":</u> Patient must indicate the number of times <i>in the past 3 months</i> , on average they overused diuretics in order to avoid gaining weight after binge eating.
	5.	Patient must record "No" or "Yes" if they have ever in the past 3 months fast for at least 24 hours to avoid gaining weight after binge eating.
		If patient answers "No": Patient may skip to question 6.
		<u>If patient answers "Yes":</u> Patient must indicate the number of times <i>in the past 3 months</i> , on average they fasted for at least 24 hours in order to avoid gaining weight after binge eating.
	6.	Patient must record "No" or "Yes" if they have ever <i>in the past 3 months</i> exercise for more than and hour specifically to avoid gaining weight after binge eating.
		If patient answers "No": Patient may skip to question 7.
		<u>If patient answers "Yes":</u> Patient must indicate the number of times <i>in the past 3 months</i> , on average they exercised for more than an hour specifically to avoid gaining weight after binge eating.

DATA SECTION		COMPLETION INSTRUCTIONS
	7.	Patient must record "No" or "Yes" if they have ever in the past 3 months taken more than twice the recommended dose of a diet pill in order to avoid gaining weight after binge eating.
		If patient answers "No": Patient may skip to question 8.
		If patient answers "Yes": Patient must indicate the number of times in the past 3 months, on average they took more than twice the recommended dose of a diet pill in order to avoid gaining weight after binge eating.
	8.	Patient must record "No" or "Yes" if they have ever <i>in the past 3 months</i> withheld insulin for weight control. If patient does not use insulin, they must mark the box "-2" indicating so.
EATING HABITS IN THE PAST 3 MONTHS:	1.	Patient records amount of daily food intake consumed after suppertime.
	2.	Patient records their usual level of hunger in the morning.
	3.	Patient records amount of difficulty that they experienced falling to sleep.
	4.	Patient records how many times they got up at least once in the middle of the night, excluding getting up to use the bathroom.
		<u>If patient answers "Never":</u> Patient may skip to question 6.
	5.	Patient must record number of times that patient got up to snack in the middle of the night.
		If patient answers "Never": Patient may skip to question 6.
	5.1	If patient gets up in the middle of the night to snack, patient must record how aware they were of their eating.

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DATA SECTION		COMPLETION INSTRUCTIONS
	6.	Patient records "No" or "Yes" if they were in an occupation involving night or evening shifts or other unusual time requirements, which interfere with meals.
	7.	Patient records frequency of eating a meal even though they were not hungry any more.
	8.	Patient records frequency of eating a meal even though they felt full.
TOBACCO USE:	1.	Patient records "No" or "Yes" if they currently smoke cigarettes.
	1.1	If "Yes": Patient must list number of packs per day they currently smoke.
ALCOHOL USE:	1.	Patient records number of times <i>in the past 12 months</i> they had a drink containing alcohol.
		If "Never": Patient may skip to question 1 of the next section regarding substance use.
	2.	Patient indicates number of drinks containing alcohol that they have on a typical day when they are drinking.
		If a participant reports in the LABS 2 self-assessment packet that he/she drinks 5 or more drinks on a typical day when drinking (see question below), the coordinator must notify the patient's surgeon or a pre-determined designee* of the patient's alcohol consumption within 24 hours of the research visit or receipt of the survey by mail. However, if the participant is scheduled for surgery within 48 hours of the visit, the coordinator should alert the surgeon while the patient is still in the office.
		Coordinators should inform the participant that the surgeon/clinician will be contacted about the level of alcohol consumption.
		The coordinator should make notation of this contact in the participant's research file, but should not be

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		involved in any follow-up regarding the patient's alcohol use.
		* The PI at each site may designate a clinician, such as a nurse practitioner or physician's assistant, to receive this information and share it with the patient's surgeon. Surgeons and clinicians involved with the care of LABS participants should be familiar with the AUDIT tool and this particular question which is based on alcohol consumption during the last 12 months and does not include how often the patient drinks.
	3.	Patient indicates number of times that they have more than six drinks on one occasion.
	4.	Patient indicates, <i>in the past 12 months</i> , how often they found that they were not able to stop drinking after they had started.
	5.	Patient indicates, <i>in the past 12 months</i> , how often they have failed to do normal activities as expected because of their drinking.
	6.	Patient indicates, <i>in the past 12 months</i> , how many times they needed a drink in the morning after drinking the evening before.
	7.	Patient indicates <i>in the past 12 months</i> , how many times they felt guilty after drinking.
DATA SECTION	0	COMPLETION INSTRUCTIONS
	8.	Patient indicates <i>in the past 12 months</i> , how many times they had been unable to remember events from the night before because they had been drinking.
	9.	Patient indicates if someone else has <i>ever</i> been injured as a result of their drinking.
	10.	Patient indicates if a relative or friend, doctor or health care worker has <i>ever</i> suggested patient cut back on their drinking habits out of concern.
SUBTANCE USE:	1.	Patient answers "No" or "Yes" to using each of the listed substances <i>in the past 12 months</i> , whether or not prescribed by a physician.

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