

Entered: __/__/20__ mm dd yy	Initials: _____	Verified: __/__/20__ mm dd yy	Initials: _____
Patient ID _____ - _____ - _____			Visit: 1
For office use only.			

SFB – Version: 08/28/2006

Form Completion Date __/__/20__
mm dd yy

Directions: The following questions are sensitive and personal. We are asking about this area because other patients undergoing obesity surgery have told us that this is an important part of their life. Please answer each question honestly and accurately. Your answers are confidential. If you choose to skip a question **please cross it out**.

1. During the **past month**, how often have you felt sexual desire or interest, that is desire or interest to engage in any activity that is arousing to you, alone or with a partner?¹

- 1. Not at all
- 2. Once a month
- 3. Once a week
- 4. A few times a week
- 5. Once a day
- 6. More than once a day

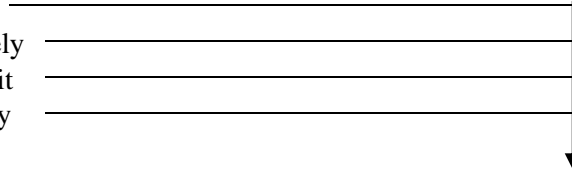
2. During the **past month**, how often have you participated in any sexual activity, that is any activity that is arousing to you, alone or with a partner?

- 1. Not at all
- 2. Once a month
- 3. Once a week
- 4. A few times a week
- 5. Once a day
- 6. More than once a day

If not at all...

2.1 I am not sexually active because (<i>Please check "no" or "yes" for each item.</i>)																							
<table style="width: 100%;"> <tr> <td style="width: 50%;">No</td> <td style="width: 50%;">Yes</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> a. I have never been sexually active</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> c. I am too tired</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> e. I am not interested</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> g. I have a physical problem that makes sexual activity difficult or uncomfortable</td> </tr> </table>	No	Yes	<input type="checkbox"/>	<input type="checkbox"/> a. I have never been sexually active	<input type="checkbox"/>	<input type="checkbox"/> c. I am too tired	<input type="checkbox"/>	<input type="checkbox"/> e. I am not interested	<input type="checkbox"/>	<input type="checkbox"/> g. I have a physical problem that makes sexual activity difficult or uncomfortable	<table style="width: 100%;"> <tr> <td style="width: 50%;">No</td> <td style="width: 50%;">Yes</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> b. I do not have a partner at this time</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> d. My partner is not interested</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> f. My partner is too tired</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> h. My partner has a physical problem that makes sexual activity difficult or uncomfortable</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> i. Other (Specify: _____)</td> </tr> </table>	No	Yes	<input type="checkbox"/>	<input type="checkbox"/> b. I do not have a partner at this time	<input type="checkbox"/>	<input type="checkbox"/> d. My partner is not interested	<input type="checkbox"/>	<input type="checkbox"/> f. My partner is too tired	<input type="checkbox"/>	<input type="checkbox"/> h. My partner has a physical problem that makes sexual activity difficult or uncomfortable	<input type="checkbox"/>	<input type="checkbox"/> i. Other (Specify: _____)
No	Yes																						
<input type="checkbox"/>	<input type="checkbox"/> a. I have never been sexually active																						
<input type="checkbox"/>	<input type="checkbox"/> c. I am too tired																						
<input type="checkbox"/>	<input type="checkbox"/> e. I am not interested																						
<input type="checkbox"/>	<input type="checkbox"/> g. I have a physical problem that makes sexual activity difficult or uncomfortable																						
No	Yes																						
<input type="checkbox"/>	<input type="checkbox"/> b. I do not have a partner at this time																						
<input type="checkbox"/>	<input type="checkbox"/> d. My partner is not interested																						
<input type="checkbox"/>	<input type="checkbox"/> f. My partner is too tired																						
<input type="checkbox"/>	<input type="checkbox"/> h. My partner has a physical problem that makes sexual activity difficult or uncomfortable																						
<input type="checkbox"/>	<input type="checkbox"/> i. Other (Specify: _____)																						

3. During the **past month**, how much has your physical health limited your sexual activity, that is any activity that is arousing to you, alone or with a partner?²

- 1. Not at all
 - 2. Slightly
 - 3. Moderately
 - 4. Quite a bit
 - 5. Extremely
- 

3.1 In what way did your physical health limit your own sexual functioning? (Please check “no” or “yes” for each item.)

<u>Women Only:</u>		<u>Men Only:</u>	
No	Yes	No	Yes
<input type="checkbox"/>	<input type="checkbox"/> Fatigue or low energy	<input type="checkbox"/>	<input type="checkbox"/> Fatigue or low energy
<input type="checkbox"/>	<input type="checkbox"/> Lack of interest in sex	<input type="checkbox"/>	<input type="checkbox"/> Lack of interest in sex
<input type="checkbox"/>	<input type="checkbox"/> Difficulty becoming aroused	<input type="checkbox"/>	<input type="checkbox"/> Difficulty becoming aroused
<input type="checkbox"/>	<input type="checkbox"/> Pain or discomfort	<input type="checkbox"/>	<input type="checkbox"/> Pain or discomfort
<input type="checkbox"/>	<input type="checkbox"/> Difficulty with vaginal lubrication	<input type="checkbox"/>	<input type="checkbox"/> Difficulty getting an erection
<input type="checkbox"/>	<input type="checkbox"/> Difficulty having an orgasm	<input type="checkbox"/>	<input type="checkbox"/> Difficulty maintaining an erection
<input type="checkbox"/>	<input type="checkbox"/> Embarrassment	<input type="checkbox"/>	<input type="checkbox"/> Difficulty ejaculating
<input type="checkbox"/>	<input type="checkbox"/> Fear of damaging my health	<input type="checkbox"/>	<input type="checkbox"/> Difficulty having an orgasm
<input type="checkbox"/>	<input type="checkbox"/> Fear of hurting my partner	<input type="checkbox"/>	<input type="checkbox"/> Embarrassment
<input type="checkbox"/>	<input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/> Fear of damaging my health
		<input type="checkbox"/>	<input type="checkbox"/> Fear of hurting my partner
		<input type="checkbox"/>	<input type="checkbox"/> Other

4. Over the **past month**, how satisfied have you been with your overall sexual life?³

- 1. Very satisfied
- 2. Moderately satisfied
- 3. About equally satisfied and dissatisfied
- 4. Moderately dissatisfied
- 5. Very dissatisfied

LABS gratefully acknowledges the following for questions contained in this form:

¹Syrjala KL, Roth-Roemer SL, Abrams JR, Scanlan JM, Chapko MK, Visser S, Sanders JE (Sep 1998) Prevalence and predictors of sexual dysfunction in long-term survivors of marrow transplantation., *Journal of Clinical Oncology : Official Journal of the American Society of Clinical Oncology.*, 16 (9), 3148-57

² PRIDE Surveys - <http://www.pridesurveys.com/index.html>

³ FSFI, Dr. Raymond Rosen

SEXUAL FUNCTIONING QUESTIONNAIRE, BASELINE (SFB)

<p>PURPOSE:</p>	<p>To collect sexual functioning information on patients aged 18 years or older enrolled in LABS-1, who have provided informed consent for LABS-2, prior to bariatric surgery.</p>
<p>PERSON(S) RESPONSIBLE: SOURCES OF INFORMATION:</p>	<p>Clinician/Coordinator Patient</p>
<p>WHEN TO ADMINISTER FORM:</p>	<p>Once patient provides informed consent for LABS-2, prior to surgery.</p> <p>This questionnaire should be completed at the baseline visit or sent to patient by mail for patient to complete at home and return to coordinator prior to bariatric surgery. If the patient completes the SFB at home, the coordinator or other study staff must review the document at patient’s clinic visit to ensure that all fields have been completed appropriately.</p>
<p>GENERAL INSTRUCTIONS (Patient)</p>	<p>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.</p>
<p>GENERAL INSTRUCTIONS: (Clinician)</p>	<p>After patient completes survey:</p> <ol style="list-style-type: none"> (1) Record whether the survey was completed by the patient alone or completed by the patient with assistance. (2) Review the form for any missing items. Follow-up with patient if necessary to record missing items, or to clarify responses. (3) Make sure that each item has a single response marked, unless directions state otherwise. (4) 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.
<p>SCORING ALGORITHM:</p>	<p>N/A</p>

DATA SECTION	COMPLETION INSTRUCTIONS
PATIENT ID:	<p>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.</p> <p><i>NOTE: The patient ID number is the same as that assigned to the patient as part of the LABS-1 study.</i></p>
VISIT:	<p>Record the visit number that the SFB corresponds to on the right hand corner of the cover page</p>
FORM COMPLETION DATE:	<p>Patient records date of form completion (mm/dd/20yy)</p> <ol style="list-style-type: none"> 1. Patient records how often in the <i>past month</i> they have felt sexual desire or interest to engage in any activity that is arousing to them, alone or with a partner. 2. Patient records how often in the <i>past month</i> they have participated in any sexual activity. <p><u>If patient selects "Not at all":</u> Patient must answer question 2.1.</p> <ol style="list-style-type: none"> 2.1 Patient records "No" or "Yes" for each item, indicating why they have not been sexually active in the <i>past month</i>. If patient selects "Other" they may use the blank space to specify any other reason for why they have not been sexually active, other than what is listed. 3. Patient records how much their <u>physical health</u> has limited their sexual activity in the <i>past month</i>. <p><u>If patient selects "Not at all":</u> Patient may skip to question 4.</p> <ol style="list-style-type: none"> 3.1 Patient records "No" or "Yes" for each item. Women need only answer the left column, marked "Women Only", men need only answer the right column, marked "Men Only". 4. Patient indicates overall satisfaction with sexual life over the <i>past month</i>. Note that his satisfaction level should be rated even if the patient is not sexual active.