Entered: _ _ / _ _ / 20_ _ (mm dd yy)	Initials: ________	Verified: _ _ / _ _ /20 _ _ (mm dd yy)	Initials: ________
Patient ID __ __ __ - __ __ __ __ - __ __			**Visit: 1**

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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?

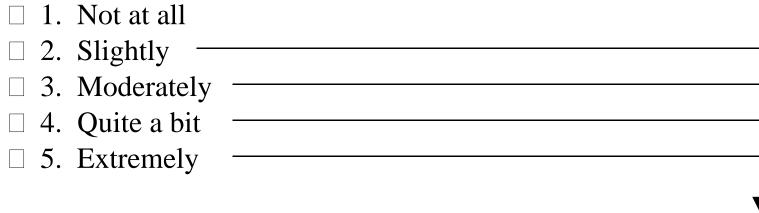
- ☐ 1. Not at all →
- ☐ 2. Once a month
- ☐ 3. Once a week
- ☐ 4. A few times a week
- ☐ 5. Once a day
- ☐ 6. More than once a day

If not at all…

2.1 I am not sexually active because *(Please check "no" or "yes" for each item.)*

No	Yes		No	Yes	
☐	☐	a. I have never been sexually active	☐	☐	b. I do not have a partner at this time
☐	☐	c. I am too tired	☐	☐	d. My partner is not interested
☐	☐	e. I am not interested	☐	☐	f. My partner is too tired
☐	☐	g. I have a physical problem that makes sexual activity difficult or uncomfortable	☐	☐	h. My partner has a physical problem that makes sexual activity difficult or uncomfortable
			☐	☐	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.)*

Women Only:

No	Yes	
☐	☐	Fatigue or low energy
☐	☐	Lack of interest in sex
☐	☐	Difficulty becoming aroused
☐	☐	Pain or discomfort
☐	☐	Difficulty with vaginal lubrication
☐	☐	Difficulty having an orgasm
☐	☐	Embarrassment
☐	☐	Fear of damaging my health
☐	☐	Fear of hurting my partner
☐	☐	Other

Men Only:

No	Yes	
☐	☐	Fatigue or low energy
☐	☐	Lack of interest in sex
☐	☐	Difficulty becoming aroused
☐	☐	Pain or discomfort
☐	☐	Difficulty getting an erection
☐	☐	Difficulty maintaining an erection
☐	☐	Difficulty ejaculating
☐	☐	Difficulty having an orgasm
☐	☐	Embarrassment
☐	☐	Fear of damaging my health
☐	☐	Fear of hurting my partner
☐	☐	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:

[1]Syrjala 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

Entered: _ _ / _ _ / 20_ _ (mm dd yy)	Initials: ________	Verified: _ _ / _ _ /20 _ _ (mm dd yy)	Initials: ________
Patient ID __ __ __ - __ __ __ __ - __ __			**Visit:**____

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RHB –Version 08/28/2006

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

The following set of questions is for females only.

1. Have you had irregular periods (less than 8 periods a year) throughout life **starting in your teens**? ☐ 0. No ☐ 1. Yes

2. Have you ever had the following symptoms **before age 45?**

2.1 Excess facial, chest or body hair	☐ 0. No	☐ 1. Yes
2.2 Male pattern baldness, such as thinning of hair at the crown or temple	☐ 0. No	☐ 1. Yes
2.3 Severe **adult** acne	☐ 0. No	☐ 1. Yes

3. Has a healthcare professional ever told you that you have/had polycystic ovary syndrome (PCOS)?
☐ 0. No → *Go to question 4*
☐ 1. Yes →

Are you currently treating your PCOS?
☐ 0. No → *Go to question 4*
☐ 1. Yes →

3.1 How are you currently treating your PCOS? *(Check "no" or "yes" to each)*

No	Yes		No	Yes	
☐	☐	Exercise	☐	☐	Prescription medication
☐	☐	Diet			

4. In the **past 12 months** have you taken any hormonal medication, such as HRT, the pill, or fertility medication?
☐ 0. No → *Go to question 5*
☐ 1. Yes →

4.1 Please indicate which type of hormonal medication you have taken in the **past 12 months**:
☐ 1. Hormone replacement therapy → *Skip to question 9, next page*
☐ 2. Hormonal birth control (such as pill, ring, shot, Mirena) → *Skip to question 12, next page*
☐ 3. Fertility medication → *Skip to question 12, next page*

Thinking back over the **past 12 months…**

5. In how many of those months did you have a period? #_______ ***If zero, please skip to question 9, next page***

6. What was the usual length of your menstrual cycle (interval from the first day of period to the first day of next period)?
☐ 1. Less than 21 days ☐ 2. 21 – 35 days ☐ 3. More than 35 days ☐ 4. Too irregular to estimate

6. On average, how many days did your period (bleeding) last?
   - ☐ 1. 1 – 4 days
   - ☐ 2. 5 – 7 days
   - ☐ 3. 8 – 9 days
   - ☐ 4. More than 9 days

8. Did you have spotting or bleeding that occurred at times other than your menstrual period?
   - ☐ 0. No → *Skip to question 12*
   - ☐ 1. Yes →

   8.1 In how many of the **past 12 months** did this occur? ______ (months) → *Skip to question 12*

9. How old where you when you had your last natural menstrual period? _________ (years)

10. Why did your natural menstrual period stop?
    - ☐ 1. Medication
    - ☐ 2. Natural menopause
    - ☐ 3. Hysterectomy
    - ☐ 4. Chemotherapy
    - ☐ 5. Chronic illness
    - ☐ 6. Prolactin, adrenal gland or thyroid problem
    - ☐ 7. Pregnancy
    - ☐ 8. No known reason
    - ☐ 9. Other (Specify: ________________________)

11. Please indicate how bothersome the following symptoms have been in the **past month:**

	Not at all (1)	Slightly (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
11.1 Hot flashes or flushes	☐	☐	☐	☐	☐
11.2 Sleep disturbance (difficulty falling or staying asleep or early wakening)	☐	☐	☐	☐	☐
11.3 Vaginal dryness	☐	☐	☐	☐	☐

12. Have you **ever** tried to become pregnant?
    - ☐ 0. No → *Skip to question 16*
    - ☐ 1. Yes

13. 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?
    - ☐ 0. No
    - ☐ 1. Yes → Specify age this first happened: __ __ (years)

14. Have you **ever** talked to a doctor or had tests done because of problems becoming pregnant?
    - ☐ 0. No → *Skip to question 16*
    - ☐ 1. Yes

15. Have you **ever** taken any fertility medication to help you become pregnant (such as Clomid, Serophene, Gonal-F, Follistim)?
    - ☐ 0. No
    - ☐ 1. Yes

16. Total number of times you have been pregnant? # ________ ***If zero, please skip to question 17.***

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), or miscarriage (fetus lost before 20 weeks or 5 months) or other outcome

	your age	fertility med used? No (0)	Yes (1)	*Please check one outcome per pregnancy* live birth (1)	still birth (2)	miscarriage (3)	other outcome (4)
Preg. 1	_______	☐	☐	☐	☐	☐	☐
Preg. 2	_______	☐	☐	☐	☐	☐	☐
Preg. 3	_______	☐	☐	☐	☐	☐	☐
Preg. 4	_______	☐	☐	☐	☐	☐	☐
Preg. 5	_______	☐	☐	☐	☐	☐	☐
Preg. 6	_______	☐	☐	☐	☐	☐	☐
Preg. 7	_______	☐	☐	☐	☐	☐	☐
Preg. 8	_______	☐	☐	☐	☐	☐	☐

☐ I have had more than 8 pregnancies

If you are 50 years old or older, please skip Questions 17-20. If you are 49 or younger please continue.

17. In the **past 12 months** have you used (or has your partner used) birth control for any reason?

☐ 0. No → *Skip to question 19*

☐ 1. Yes ↓

17.1 Specify method of birth control you have used in the **past 12 months** (*Check "no" or "yes" for each item*).

No	Yes	
☐	☐	Pills, monthly (including one week of placebo or no pills, get period)
☐	☐	Pills, continuous use (new pack every 3 weeks, no period)
☐	☐	Mini Pill, continuous use (progestin only, get period)
☐	☐	Patch or ring
☐	☐	Injections of medications (shots) or implantation of a medication release device
☐	☐	IUD → ☐ Mirena ☐ Copper ☐ Don't know
☐	☐	Diaphragm
☐	☐	Cervical cap
☐	☐	Male or female condom
☐	☐	Contraceptive foams, creams, jellies
☐	☐	Natural family planning, rhythm method or having sex during "safe" times
☐	☐	Withdrawal
☐	☐	Hysterectomy: your uterus was surgically removed
☐	☐	Tubal ligation: your tubes were tied
☐	☐	Vasectomy: your partner was sterilized
☐	☐	Other (Specify:___________________)

18. In the **past 12 months** how often have you used birth control when having sexual intercourse with a man?

☐ 0. Not sexually active with a man
☐ 1. Never
☐ 2 Rarely
☐ 3. About half the time
☐ 4. Most of the time
☐ 5. All of the time

19. 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. # _____ (0 – 10)

20. When do you think you will try to become pregnant?

☐ 1. Never ☐ 2. In next 12 months ☐ 3. In next 12-24 months ☐ 4. After 24 months ☐ 5. Not sure

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Patient ID __ __ __ - __ __ __ __ - __ __   **Visit: 1**

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UIB – Version: 08/28/2006

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

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 *check one box only*).

- ☐ 1. Never → *Skip to question 8*
- ☐ 2. Less than once per month → *Skip to question 8*
- ☐ 3. Monthly (once or more each month) → *Skip to question 8*
- ☐ 4. Weekly (once or more each week)
- ☐ 5. 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?

- ☐ 1. Drops
- ☐ 2. Small splashes (1 to 2 teaspoons)
- ☐ 3. 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?

☐ 0. No → *Skip to question 5*   ☐ 1. Yes ↓

4.1 How many of each of the supplies listed below have you used **in a typical week specifically for your urine leakage**?

a. Pantyliners 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

5. In the past 3 months, have you had treatments for urine leakage? ☐ 0. No ☐ 1. Yes

If yes, check "no" or "yes" to each:

No	Yes	
☐	☐	a. Medication
☐	☐	b. Kegel exercises, biofeedback, bladder training (behavioral therapy)
☐	☐	c. Changes in fluid intake (decrease fluids, stop caffeine)
☐	☐	d. Other (Please describe ___________________________________)

6. In the **<u>past 3 months,</u>** how much has your urine leakage **affected your day-to-day activities**?

Not at all	Slightly	Moderately	Quite a bit	Extremely
(1)	(2)	(3)	(4)	(5)
☐	☐	☐	☐	☐

7. In the **<u>past 3 months,</u>** how much has your urine leakage **bothered** you?

Not at all	Slightly	Moderately	Quite a bit	Extremely
(1)	(2)	(3)	(4)	(5)
☐	☐	☐	☐	☐

8. Have you **ever** had surgery for urine leakage?

☐ 0. No ☐ 1. Yes → When: __ __ __ __ (year)