A. Complaints

Below is a list of complaints people sometimes have. For each item, check the one that best describes how bothersome the complaint was for you during the past 4 weeks. Be sure to mark one box for each complaint listed. If you did not have the problem, please check the box under "did not occur." If you had the complaint, use the following key to indicate how bothersome it was:

- mild = complaint did not interfere with usual activities.
- moderate = complaint interfered somewhat with usual activities.
- severe = complaint was so bothersome that usual activities could not be performed.

1. Heartburn (burning sensation in chest or upper abdomen)

   schrbrn

   1. Did not occur
   2. Mild
   3. Moderate
   4. Severe

2. Regurgitation (the involuntary movement of liquids and foods from the stomach up into the throat)

   scregurg

   1. Did not occur
   2. Mild
   3. Moderate
   4. Severe

3. Nausea (feeling sick to your stomach as if you were going to throw up or vomit)

   scnausea

   1. Did not occur
   2. Mild
   3. Moderate
   4. Severe

4. Abdominal pain above the navel
5. Vomiting

6. Feeling very full after eating only a little bit of a meal

7. Bloating or distention (your abdomen feels swollen or gassy)

8. Constipation

9. Diarrhea
A. Complaints - continued

10. Abdominal pain below the navel
   scdiarr
   1. Did not occur
   2. Mild
   3. Moderate
   4. Severe

11. Leg or arm pain during or following exercise
   sclegpn
   1. Did not occur
   2. Mild
   3. Moderate
   4. Severe

12. Swollen or sore joints during or following exercise
   scswjnts
   1. Did not occur
   2. Mild
   3. Moderate
   4. Severe

13. A pulled or strained muscle, tendon, or ligament during or following exercise
   scmusc
   1. Did not occur
   2. Mild
   3. Moderate
   4. Severe
14. Sores on your feet that heal poorly

scfsore

1. Did not occur
2. Mild
3. Moderate
4. Severe

15. Swelling of the feet or ankles

scfswell

1. Did not occur
2. Mild
3. Moderate
4. Severe

16. Chest pain/angina/heart pain

scangina

1. Did not occur
2. Mild
3. Moderate
4. Severe

17. Palpitations/heart racing/heart skipping beats

schpalp

1. Did not occur
2. Mild
3. Moderate
4. Severe

18. Shortness of breath with exercise

scshbth1

1. Did not occur
2. Mild
3. Moderate
4. Severe

19. Shortness of breath lying down or waking you up at night
20. Dizzy or lightheaded when you stand up

21. Dizzy or lightheaded anytime

22. Worsening of your eyesight

23. Numbness or weakness of one arm or leg
24. Have you experienced low blood sugar in the last 3 months?

- sclbs
  - 1 Yes
  - 2 No

  ➤ If No, Go to Section B, "Knees"

➤ If Yes,
  How many times was your low blood sugar so severe that you had to be in the hospital?
  - schscnt (Number of times, "0" if none)

  How many times was your low blood sugar so severe that you had to visit the emergency room, but not be admitted to the hospital?
  - scercent (Number of times, "0" if none)

  How many times was your low blood sugar so severe that you needed someone to help you but not ER visit or hospitalization?
  - schpcnt (Number of times, "0" if none)

  How many times have you had low blood sugar in the last 7 days?
  - sclbcnt (Number of times, "0" if none)

  Did any of these times occur without symptoms?
  - scnosymp

  Did any of these times result in injury to yourself or to others?
  - scinjury

  Did any of these times occur when you were asleep?
  - scasleep

25. Was your blood sugar checked during the most severe episode of low blood sugar?

- sccheck
26. Has your medicine for diabetes been changed as a result of these episodes of low blood sugar?

- [ ] Yes
- [ ] No

If Yes, Who changed your diabetes medicine?

- [ ] Primary care physician
- [ ] Look AHEAD personnel
- [ ] Other, specify

Specify:
A. Complaints

Below is a list of complaints people sometime have. For each item, check the one that best describes how bothersome the complaint was for you during the past 4 weeks. Be sure to mark one box for each complaint listed. If you did not have the problem, please check the box under "did not occur." If you had the complaint, use the following key to indicate how bothersome it was:

- **Mild** = complaint did not interfere with usual activities.  
- **Moderate** = complaint interfered somewhat with usual activities.  
- **Severe** = complaint was so bothersome that usual activities could not be performed

<table>
<thead>
<tr>
<th>Complaint</th>
<th>Did not occur</th>
<th>Complaint occurred and was:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Mild</td>
</tr>
<tr>
<td>1. Heartburn</td>
<td>1 □</td>
<td>2 □</td>
</tr>
<tr>
<td>(burning sensation in chest or upper abdomen)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Regurgitation</td>
<td>1 □</td>
<td>2 □</td>
</tr>
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<td>(the involuntary movement of liquids or foods from the stomach up into the throat)</td>
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<td></td>
</tr>
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<td>3. Nausea</td>
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</tr>
<tr>
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<td></td>
<td></td>
</tr>
<tr>
<td>4. Abdominal pain above the navel</td>
<td>1 □</td>
<td>2 □</td>
</tr>
<tr>
<td>5. Vomiting</td>
<td>1 □</td>
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</tr>
<tr>
<td>6. Feeling very full after eating only a little bit of a meal</td>
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<td>2 □</td>
</tr>
<tr>
<td>7. Bloating or distention</td>
<td>1 □</td>
<td>2 □</td>
</tr>
<tr>
<td>(your abdomen feels swollen or gassy)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Constipation</td>
<td>1 □</td>
<td>2 □</td>
</tr>
<tr>
<td>9. Diarrhea</td>
<td>1 □</td>
<td>2 □</td>
</tr>
</tbody>
</table>
## A. Complaints

<table>
<thead>
<tr>
<th>Complaint</th>
<th>Did not occur</th>
<th>Complaint occurred and was:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Mild</td>
</tr>
<tr>
<td>10. Abdominal pain below the navel</td>
<td>1 ☐</td>
<td>2 ☐</td>
</tr>
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<td>11. Leg or arm pain during or following exercise</td>
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</tr>
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<td>2 ☐</td>
</tr>
<tr>
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<td>1 ☐</td>
<td>2 ☐</td>
</tr>
</tbody>
</table>
A. Complaints

24. Have you experienced low blood sugar in the last 3 months?
   1 □ Yes ➔
   How many times was your low blood sugar so severe that you had to be in the hospital? [number of times, "00" if none]
   How many times was your low blood sugar so severe you had to visit the emergency room, but not be admitted to the hospital? [number of times, "00" if none]
   How many times was your low blood sugar so severe that you needed someone to help you (but not ER visit or hospitalization)? [number of times, "00" if none]
   How many times have you had low blood sugar in the last 7 days? [number of times, "00" if none]

   Did any of these times occur without symptoms?  
   1 □ Yes 2 □ No

   Did any of these times result in injury to yourself or to others?  
   1 □ Yes 2 □ No

   Did any of these times occur when you were asleep?  
   1 □ Yes 2 □ No

   2 □ No ➔ Go to Section B, "Knees," next page

25. Was your blood sugar checked during the most severe episode of low blood sugar?
   1 □ Yes ➔
   What was the glucose value?

   2 □ No

26. Has your medicine for diabetes been changed as a result of these episodes of low blood sugar?
   1 □ Yes ➔
   Who changed your diabetes medicines?

   2 □ No
   1 □ Primary Care Physician
   2 □ Look AHEAD Personnel
   3 □ Other
**B. Knees**

Have you had any pain or discomfort in your knees **in the past month**?

1. □ Yes ➔ CONTINUE
2. □ No ➔ Go to Section C, "Urinary History"

1. Please mark an X on the scale for how bad the **pain** in your **right** knee has been **in the past 2 weeks**.

   ![Pain Scale](image)

   For office use only:
   ![Office Use Scale](image)

2. Please mark an X on the scale for how bad the **pain** in your **left** knee has been **in the past 2 weeks**.

   ![Pain Scale](image)

   For office use only:
   ![Office Use Scale](image)

The following questions concern the amount of pain you have experienced in your knee(s). For each situation please enter the amount of pain experienced **in the last 2 weeks**.

**QUESTION: How much pain do you have?**

3. Walking on a flat surface.
   - 1 □ None  
   - 2 □ Mild  
   - 3 □ Moderate  
   - 4 □ Severe  
   - 5 □ Extreme

4. Going up or down stairs.
   - 1 □ None  
   - 2 □ Mild  
   - 3 □ Moderate  
   - 4 □ Severe  
   - 5 □ Extreme

5. At night while in bed.
   - 1 □ None  
   - 2 □ Mild  
   - 3 □ Moderate  
   - 4 □ Severe  
   - 5 □ Extreme

6. Sitting or lying.
   - 1 □ None  
   - 2 □ Mild  
   - 3 □ Moderate  
   - 4 □ Severe  
   - 5 □ Extreme

7. Standing upright.
   - 1 □ None  
   - 2 □ Mild  
   - 3 □ Moderate  
   - 4 □ Severe  
   - 5 □ Extreme
### B. Knees

The following questions concern the amount of joint stiffness (not pain) you have experienced in the last 2 weeks in your knee(s). Stiffness is a sensation of restriction or slowness in the ease with which you move your joints.

8. How **severe** is your stiffness **after first wakening** in the morning?
   - 1 None
   - 2 Mild
   - 3 Moderate
   - 4 Severe
   - 5 Extreme

9. How **severe** is your stiffness after sitting, lying or resting **later in the day**?
   - 1 None
   - 2 Mild
   - 3 Moderate
   - 4 Severe
   - 5 Extreme

The following questions concern your physical function. By this we mean your ability to move around and to look after yourself. For each of the following activities, please indicate the degree of difficulty you have experienced in the last 2 weeks due to arthritis, pain or discomfort in your knee(s).

**QUESTION:** What degree of difficulty do you have?

10. Descending stairs.
    - 1 None
    - 2 Mild
    - 3 Moderate
    - 4 Severe
    - 5 Extreme

11. Ascending stairs.
    - 1 None
    - 2 Mild
    - 3 Moderate
    - 4 Severe
    - 5 Extreme

12. Rising from sitting.
    - 1 None
    - 2 Mild
    - 3 Moderate
    - 4 Severe
    - 5 Extreme

    - 1 None
    - 2 Mild
    - 3 Moderate
    - 4 Severe
    - 5 Extreme

14. Bending to floor.
    - 1 None
    - 2 Mild
    - 3 Moderate
    - 4 Severe
    - 5 Extreme

15. Walking on flat.
    - 1 None
    - 2 Mild
    - 3 Moderate
    - 4 Severe
    - 5 Extreme

    - 1 None
    - 2 Mild
    - 3 Moderate
    - 4 Severe
    - 5 Extreme
<table>
<thead>
<tr>
<th></th>
<th>B. Knees</th>
</tr>
</thead>
<tbody>
<tr>
<td>17</td>
<td>Going shopping.</td>
</tr>
<tr>
<td></td>
<td>1 None 2 Mild 3 Moderate 4 Severe 5 Extreme</td>
</tr>
<tr>
<td>18</td>
<td>Putting on socks/stockings.</td>
</tr>
<tr>
<td></td>
<td>1 None 2 Mild 3 Moderate 4 Severe 5 Extreme</td>
</tr>
<tr>
<td>19</td>
<td>Rising from bed.</td>
</tr>
<tr>
<td></td>
<td>1 None 2 Mild 3 Moderate 4 Severe 5 Extreme</td>
</tr>
<tr>
<td>20</td>
<td>Taking off socks/stockings.</td>
</tr>
<tr>
<td></td>
<td>1 None 2 Mild 3 Moderate 4 Severe 5 Extreme</td>
</tr>
<tr>
<td>21</td>
<td>Lying in bed.</td>
</tr>
<tr>
<td></td>
<td>1 None 2 Mild 3 Moderate 4 Severe 5 Extreme</td>
</tr>
<tr>
<td>22</td>
<td>Getting in/out of bath.</td>
</tr>
<tr>
<td></td>
<td>1 None 2 Mild 3 Moderate 4 Severe 5 Extreme</td>
</tr>
<tr>
<td>23</td>
<td>Sitting.</td>
</tr>
<tr>
<td></td>
<td>1 None 2 Mild 3 Moderate 4 Severe 5 Extreme</td>
</tr>
<tr>
<td>24</td>
<td>Getting on/off toilet.</td>
</tr>
<tr>
<td></td>
<td>1 None 2 Mild 3 Moderate 4 Severe 5 Extreme</td>
</tr>
<tr>
<td>25</td>
<td>Heavy domestic duties.</td>
</tr>
<tr>
<td></td>
<td>1 None 2 Mild 3 Moderate 4 Severe 5 Extreme</td>
</tr>
<tr>
<td>26</td>
<td>Light domestic duties.</td>
</tr>
<tr>
<td></td>
<td>1 None 2 Mild 3 Moderate 4 Severe 5 Extreme</td>
</tr>
</tbody>
</table>
The following questions are about your urinary or bladder habits. These questions may seem personal or embarrassing, but your answers are important for research on these common health issues.

1. **In the past 12 months**, have you been told by a doctor that you had an infection of your bladder (urinary tract infection) or kidneys?
   - [ ] Yes
   - [ ] No
   - [ ] I don't know if it was an infection of my bladder or of my kidneys.

   a. Number of bladder (urinary tract) infections in the last year
   b. Number of kidney infections in the last year

2. **In the past 7 days**, on average, how many times each day have you had **to go to the bathroom to urinate**?
   - a. during the day? [ ] times per day
   - b. during the night after going to bed? [ ] times per night

3. Many people complain that they leak urine or wet themselves accidentally. **In the past 12 months**, have you **leaked even a small amount of urine? (Check one only)**
   - [ ] None
   - [ ] Less than once per month
   - [ ] One or more times per month
   - [ ] One or more times per week
   - [ ] Every day

4. **Have you leaked even a small amount of urine or wet yourself in the past 7 days?**
   - [ ] Yes
   - [ ] No
   a. An activity like coughing, sneezing, lifting, or exercise. [ ] times in the last week
   b. An urge to urinate and couldn't get to the bathroom fast enough. [ ] times in the last week
   c. Other reasons or don't know. [ ] times in the last week
### D. Weight History

1. How much did you weigh when you were 20 years old? ____________ pounds
2. How much did you weigh when you were 30 years old? ____________ pounds
3. How much did you weigh when you were 40 years old? ____________ pounds
4. How much did you weigh when you were 50 years old? ____________ pounds
   *(Do not answer if you have not reached 50 years of age yet.)*
5. How much did you weigh when you were 60 years old? ____________ pounds
   *(Do not answer if you have not reached 60 years of age yet.)*
6. How much did you weigh when you were 70 years old? ____________ pounds
   *(Do not answer if you have not reached 70 years of age yet.)*
7. What is the most you have ever weighed, not counting pregnancies? ____________ pounds
8. Since you were 20 years old, how many different times did you lose each of the following amounts of weight ON PURPOSE (not including pregnancy or childbirth)?
   
   Please check one box for each row, even if the answer is zero.
   
<table>
<thead>
<tr>
<th>Amount</th>
<th>0 times</th>
<th>1-2 times</th>
<th>3-4 times</th>
<th>5-6 times</th>
<th>7+ times</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. 5-9 pounds</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>b. 10-19 pounds</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>c. 20-49 pounds</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>d. 50-79 pounds</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>e. 80-99 pounds</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>f. 100+ pounds</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>
D. Weight History

9. Since you were 20 years old, how many different times did you lose each of the following amounts of weight NOT ON PURPOSE (not including pregnancy or childbirth)?

Please check one box for each row, even if the answer is zero.

<table>
<thead>
<tr>
<th></th>
<th>0 times</th>
<th>1-2 times</th>
<th>3-4 times</th>
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<tr>
<td>a. 5-9 pounds</td>
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