Your Health
– and –
Well-Being

Weight-Related Symptom Measure (WRSM)

This questionnaire asks for your views about your health and your weight.

Thank you for completing this questionnaire!

Instructions for the completion of the quality-of-life questionnaire by study participants

1) This questionnaire is an important part of your overall medical evaluation. The questions are designed to collect information about how your health has affected your quality of life from your own point of view.

2) Complete the questionnaire using a ballpoint pen. Press firmly and write neatly to ensure that your answers are clear and legible.

3) Please take the time to read and answer each question carefully. Some questions may look similar to others, but each one is different.

4) Please answer every question by putting an ☒ in the box that best describes your answer. You may change an answer by drawing a line (–☒–) through the selection you wish to change and putting an ☒ in the box corresponding to the new choice.

5) There are no right or wrong answers. If you are unsure about how to answer a question, please give the best answer you can.

6) Your answers are confidential. The study coordinator will check for completeness only and will not share your answers with other clinical staff.

Weight-Related Symptoms and How Much They Bother You

For each of the following questions, read the list of symptoms below, and mark an ☒ in the one box that best describes your answer.

a. In the past 4 weeks, did you have the following symptoms?			**b. If Yes, to what extent did these symptoms bother you?**						
No	Yes	SYMPTOMS	Not at all	To a very little extent	To a little extent	To a moderate extent	To a great extent	To a very great extent	To an extremely great extent
☐0	☐1	Shortness of breath	☐0	☐1	☐2	☐3	☐4	☐5	☐6
☐0	☐1	Tiredness	☐0	☐1	☐2	☐3	☐4	☐5	☐6
☐0	☐1	Sleep problems	☐0	☐1	☐2	☐3	☐4	☐5	☐6
☐0	☐1	Sensitivity to cold	☐0	☐1	☐2	☐3	☐4	☐5	☐6
☐0	☐1	Increased thirst	☐0	☐1	☐2	☐3	☐4	☐5	☐6
☐0	☐1	Increased irritability	☐0	☐1	☐2	☐3	☐4	☐5	☐6
☐0	☐1	Back pain	☐0	☐1	☐2	☐3	☐4	☐5	☐6
☐0	☐1	Frequent urination	☐0	☐1	☐2	☐3	☐4	☐5	☐6
☐0	☐1	Pain in the joints (hips, knees, etc.)	☐0	☐1	☐2	☐3	☐4	☐5	☐6
☐0	☐1	Water retention (swelling)	☐0	☐1	☐2	☐3	☐4	☐5	☐6
☐0	☐1	Foot problems	☐0	☐1	☐2	☐3	☐4	☐5	☐6
☐0	☐1	Sensitivity to heat	☐0	☐1	☐2	☐3	☐4	☐5	☐6
☐0	☐1	Snoring	☐0	☐1	☐2	☐3	☐4	☐5	☐6

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a. **In the past 4 weeks, did you have the following symptoms?**			**b.** **If Yes, how much did these symptoms bother you?**						
No	Yes	SYMPTOMS	Not at all	To a very little extent	To a little extent	To a moderate extent	To a great extent	To a very great extent	To an extremely great extent
☐0	☐1	Increased appetite	☐0	☐1	☐2	☐3	☐4	☐5	☐6
☐0	☐1	Leakage of urine	☐0	☐1	☐2	☐3	☐4	☐5	☐6
☐0	☐1	Lightheadedness (feeling faint)	☐0	☐1	☐2	☐3	☐4	☐5	☐6
☐0	☐1	Increased sweating	☐0	☐1	☐2	☐3	☐4	☐5	☐6
☐0	☐1	Loss of sexual desire	☐0	☐1	☐2	☐3	☐4	☐5	☐6
☐0	☐1	Decreased physical stamina	☐0	☐1	☐2	☐3	☐4	☐5	☐6
☐0	☐1	Skin irritation	☐0	☐1	☐2	☐3	☐4	☐5	☐6

Please go back to the questions you just answered to make sure you did not miss any items.

Thank you for completing this questionnaire!