Your Health
– and –
Well-Being

Obesity and Weight-Loss Quality-of-Life Instrument (OWLQOL)

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

Thank you for completing these questions!

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

1) These questionnaires are 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 print neatly when writing to ensure that the copies are clear and legible.

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

4) Please answer every question by marking an ☒ in the box that best describes your answer. You may change an answer by placing a line (☒) through the selection you wish to change and marking 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 not share your answers with other clinical staff.

Your Feelings About Your Weight

Below is a list of statements about your quality of life in relation to being overweight and trying to lose weight.

For each of the following statements, please mark an ☒ in the <u>one</u> box that best describes your answer <u>at this time</u>.

	NOT AT ALL	HARDLY	SOME-WHAT	MODER-ATELY	A GOOD DEAL	A GREAT DEAL	A VERY GREAT DEAL
1. Because of my weight, I try to wear clothes that hide my shape (*Please check one*)	☐0	☐1	☐2	☐3	☐4	☐5	☐6
2. I feel frustrated that I have less energy because of my weight (*Please check one*)	☐0	☐1	☐2	☐3	☐4	☐5	☐6
3. I feel guilty when I eat because of my weight (*Please check one*)	☐0	☐1	☐2	☐3	☐4	☐5	☐6
4. I am bothered by what other people say about my weight (*Please check one*)	☐0	☐1	☐2	☐3	☐4	☐5	☐6
5. Because of my weight, I try to avoid having my photograph taken (*Please check one*)	☐0	☐1	☐2	☐3	☐4	☐5	☐6
6. Because of my weight, I have to pay close attention to personal hygiene (*Please check one*)	☐0	☐1	☐2	☐3	☐4	☐5	☐6
7. My weight prevents me from doing what I want to do (*Please check one*)	☐0	☐1	☐2	☐3	☐4	☐5	☐6
8. I worry about the physical stress that my weight puts on my body (*Please check one*)	☐0	☐1	☐2	☐3	☐4	☐5	☐6

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	NOT AT ALL	HARDLY	SOME-WHAT	MODER-ATELY	A GOOD DEAL	A GREAT DEAL	A VERY GREAT DEAL
9. I feel frustrated that I am not able to eat what others do because of my weight (*Please check one*)	☐0	☐1	☐2	☐3	☐4	☐5	☐6
10. I feel depressed because of my weight (*Please check one*)	☐0	☐1	☐2	☐3	☐4	☐5	☐6
11. I feel ugly because of my weight (*Please check one*)	☐0	☐1	☐2	☐3	☐4	☐5	☐6
12. I worry about the future because of my weight (*Please check one*)	☐0	☐1	☐2	☐3	☐4	☐5	☐6
13. I envy people who are thin (*Please check one*)	☐0	☐1	☐2	☐3	☐4	☐5	☐6
14. I feel that people stare at me because of my weight (*Please check one*)	☐0	☐1	☐2	☐3	☐4	☐5	☐6
15. I have difficulty accepting my body because of my weight (*Please check one*)	☐0	☐1	☐2	☐3	☐4	☐5	☐6
16. I am afraid that I will gain back any weight that I lose (*Please check one*)	☐0	☐1	☐2	☐3	☐4	☐5	☐6
17. I get discouraged when I try to lose weight (*Please check one*)	☐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 these questions!

Your Health
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Weight-Related Symptom Measure (WRSM)

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

Thank you for completing these questions!

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

1) These questionnaires are 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 print neatly when writing to ensure that the copies are clear and legible.

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

4) Please answer every question by marking an ☒ in the box that best describes your answer. You may change an answer by placing a line (☒) through the selection you wish to change and marking 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 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, how much did these symptoms bother you?**						
No	Yes	SYMPTOMS	Not at all	Hardly	Some-what	Moder-ately	A good deal	A great deal	A very great deal
☐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	☐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	Hardly	Some-what	Moder-ately	A good deal	A great deal	A very great deal
☐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	☐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 these questions!