# Your Health
## *– and –*
# Well-Being

**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 |

***(Please turn the page)***

**(Continued…)**

| **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!*