



## Baseline Questionnaire

Obtained from Patient Before Surgery  
Michigan Bariatric Surgery Collaborative (MBSC)

Registry ID#: \_\_\_\_ / \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Patient's Initials: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

*Current medications (continued)*

WHAT KIND OF MEDICATIONS DO YOU TAKE?	No	Yes
<b>9. Diuretics (Water Pills)</b> Example: Loop (Furosemide, Lasix, Bumetanide, Bumex) Thiazide (Hydrochlorothiazide, HCTZ) Spironolactone, Aldactone	1. <input type="checkbox"/>	2. <input type="checkbox"/>
<b>10. Prescription pain killers</b> Example: Narcotics (Vicodin, Percocet, Darvocet, Lorcet, Roxicet, Tylenol #3, Oxycodone, Morphine, Methadone, Fentanyl Patch, Duragesic Patch, Dilaudid)	1. <input type="checkbox"/>	2. <input type="checkbox"/>
<b>Acid reflux medication(s)</b> <b>11. Proton-Pump Inhibitors</b> (Example: Prilosec, Protonix, Nexium, Prevacid, Aciphex) <b>12. H2 Blockers or antacids</b> (Example: Ranitidine, Zantac, Famotidine, Pepcid, Tums, Rolaids)	1. <input type="checkbox"/>	2. <input type="checkbox"/>
<b>13. Cholesterol-lowering drugs</b> Example: Statins (Lipitor, Zocor, Pravachol, Crestor) Fibrates/Bile Acid Sequestrants (Lopid, Gemfibrozil, Cholestyramine, Tricor, Fenofibrate) Niacin, Zetia	1. <input type="checkbox"/>	2. <input type="checkbox"/>
<b>Breathing medications</b> <b>14. Inhaled medications/Bronchodilators</b> ..... Example: Albuterol, Ventolin, Proventil, Ipratropium, Atrovent, Salmeterol, Serevent <b>15. Inhaled steroids</b> ..... Example: Fluticasone, Flovent, Budesonide, Pulmicort, Advair, Fluticasone Salmeterol <b>16. Oral steroids</b> ..... Example: Prednisone, Hydrocortisone	1. <input type="checkbox"/>	2. <input type="checkbox"/>
<b>17. Other(s): Which ones?</b>  _____ _____ _____	1. <input type="checkbox"/>	2. <input type="checkbox"/>

No                      Yes

18. Do you currently use any treatment for sleep apnea? (CPAP, BiPAP, or others)                      1.                       2.

**Please continue on to the next page**

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**Below are a set of questions that ask you about your quality of life. Please place an X through only one answer for each question.**

19. In general, my health is:	Excellent	Very good	Good	Fair	Poor
	5. <input type="checkbox"/>	4. <input type="checkbox"/>	3. <input type="checkbox"/>	2. <input type="checkbox"/>	1. <input type="checkbox"/>

20. My quality of life is:	Very good	Good	OK	Bad	Very bad
	5. <input type="checkbox"/>	4. <input type="checkbox"/>	3. <input type="checkbox"/>	2. <input type="checkbox"/>	1. <input type="checkbox"/>

	Absolutely wrong	Wrong	Half/half	True	Absolutely right
21. I like my weight	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
22. I can accept my weight	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
23. I exercise regularly	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
24. I am participating in social activities	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
25. I often spend time with my friends or family	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
26. I feel excluded from social life	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
27. I feel under pressure because of my weight	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
28. Sometimes, I feel depressed	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
29. All in all, I feel satisfied in my life	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
30. I feel self-confident	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>

	Absolutely wrong	Wrong	Half/half	True	Absolutely right
31. I feel restricted AT HOME because of my weight	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
32. I feel restricted AT WORK because of my weight	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
33. I feel restricted PRIVATELY because of my weight	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>

**Please continue on to the next page**

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Patient's Initials: \_\_\_\_

*Quality of Life (continued)*

**BECAUSE OF A PHYSICAL, MENTAL, OR EMOTIONAL PROBLEM:**

No

Yes

34. Do you need the help of other persons with PERSONAL CARE NEEDS, such as eating, bathing, dressing or getting around inside the home?

1.

2.

35. Do you need the help of other persons in handling ROUTINE NEEDS such as everyday household chores, doing necessary business, shopping, or getting around for other purposes?

1.

2.

36. Are you NOW unable to work at a job or business?

1.

2.

37. Are you limited in the kind OR amount of work you can do?

1.

2.

38. Are you LIMITED IN ANY WAY in any activities?

1.

2.

39. What is your date of birth?

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM DD YYYY

40. Do you consider yourself to be Hispanic or Latino?

1.  No    2.  Yes

41. a). Do you consider yourself to be (check all that apply):

1.  White/Caucasian
2.  Black/African American
3.  Asian
4.  Native Hawaiian/Pacific Islander
5.  American Indian/Alaskan Native
6.  Other (specify): \_\_\_\_\_

b). If more than one option was selected for question 41a, please select the ONE with which you identify most:

1.  White/Caucasian
2.  Black/African American
3.  Asian
4.  Native Hawaiian/Pacific Islander
5.  American Indian/Alaskan Native
6.  Other (specify): \_\_\_\_\_

**Please continue on to the next page**

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### 42. What is your current marital status?

1.  Married or living with significant other
2.  Widowed
3.  Divorced
4.  Separated
5.  Single (Never married)

### 43. How much education have you completed? (choose only one please)

1.  8 grades or less
2.  Some high school
3.  High school graduate or GED
4.  Some college or technical school
5.  College graduate (Bachelor's Degree)
6.  Graduate degree

### 44. Which of the following describes your current employment status? (choose only one please)

1.  Working full-time (35 hours or more per week)
2.  Working part-time (less than 35 hours a week)
3.  Unemployed/laid off and looking for work
4.  Unemployed/laid off and NOT looking for work
5.  Homemaker
6.  In school full-time
7.  Retired
8.  Disabled
9.  Other (specify): \_\_\_\_\_

### 45. a). Which of the following categories best describes your annual household income from all sources? (choose one)

1.  Less than \$10,000 per year
2.  Between \$10,000 and \$24,999 per year
3.  Between \$25,000 and \$44,999 per year
4.  Between \$45,000 and \$75,000 per year
5.  More than \$75,000 per year

### b). How many people does your annual household income currently support (the number of people for whom the annual household income provided at least 50% of their support)?

\_\_\_\_\_

**STOP. You have finished the questionnaire. Please give these 5 pages to the nurse or study coordinator. Thank you for your time and cooperation.**