

## Fear of Vomiting Questionnaire

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Please complete this questionnaire as best as you can to help us understand as much as possible about your fear.**

- 1) How old were you when you first became aware of your fear of vomiting? \_\_\_\_\_
- 2) How old were you when your fear of vomiting became a significant problem? \_\_\_\_\_
- 3) Since your fear of vomiting became a problem, what course has it taken? Please circle the letter next to the statement that best describes your problem.
  - a) It has been continuous but overall the problem has become worse
  - b) It has been continuous but overall the problem has stayed much the same
  - c) It has been continuous but overall the problem has got better
  - d) It has varied. Although it has never gone away, there have been times when the problem has been much worse and times when it has been much better
  - e) It has varied. At times it has not been a problem at all and at other times it has been worse
- 4) How old were you when you first sought help for your fear of vomiting? \_\_\_\_\_
- 5) How old are you now? \_\_\_\_\_
- 6) For how many years have you NOT vomited? \_\_\_\_\_
- 7) Sex: (Please circle)      Female      /      Male
- 8) Marital Status: (Please circle)      Single / Married or co-habiting / Divorced / Widowed
- 9) Employment Status: (Please circle)      Unemployed      /      Long-Term Sick Leave      /      Student  
    Employed or self Employed      /      Homemaker      /      Other \_\_\_\_\_
- 10) Please read all the options below and circle the letter that best describes your current situation
  - a) I only fear myself vomiting (not others)
  - b) My main fear is of myself vomiting but I have some fear of others vomiting
  - c) I fear equally myself and others vomiting
  - d) My main fear is of others vomiting but I have some fear of myself vomiting
  - e) I only fear others vomiting (not myself)

11) If you fear **others** vomiting, please circle one or more reasons for this fear.  
Please go to question 12 if you only fear yourself vomiting and not others.

- a) I may catch something from the person vomiting and then vomit myself
- b) It makes me think I could vomit one day
- c) It reminds me of past experiences of vomiting
- d) Another reason ( Please specify) \_\_\_\_\_

12) Please read all the options below and circle the letter attached to the statement that best describes your fear of vomiting whether you are in public or alone

- a) I fear myself vomiting in public or social situations only
- b) My main fear is of myself vomiting in public but I have some fear of vomiting alone
- c) I fear myself vomiting whether it is in public/social situations or alone
- d) My main fear is vomiting alone but I also have some fear of vomiting in public or social situations
- e) I fear myself vomiting only when I am alone

13) Have you ever had any experiences of vomiting in your life?      Yes                      No

If yes, please list your past experience(s) of yourself vomiting (not retching) from the earliest age you can remember up to the present day. Please use an additional sheet if you need the space.

How old were you?	How distressing is the memory of the experiences on a scale of 0-10 (0 is not at all distressing and 10 is severe)?	What were the circumstances or reasons for vomiting (e.g. infection, being drunk, pregnancy, travel sickness, food)?	Did you experience any bad consequences from vomiting (e.g. reaction of a relative)? Does the episode carry other associations from that time (e.g. other bad events happening in your life)? Do you have a sense that something bad happened (e.g. you nearly died)?

14) Have you ever had any experience of feeling nauseous or retching (but not vomiting) and feeling panicky in your life?

Yes

No

If yes, please list your past experience(s) of feeling nauseous/retching from the earliest age you can remember up to the present day. Please use an additional sheet if you need the space.

How old were you?	How distressing is the memory of the experience on a scale of 0-10 (0 is not at all distressing and 10 is severe)?	What were the circumstances or reasons for you feeling nauseous? Did you have a panic attack at the same time or severe anxiety which came on rapidly?	Were there any bad consequences from feeling sick and panicky (e.g. reaction of a relative) or other associations at the time (e.g. other bad events happening in your life?) or a sense that something bad nearly happened because of this experience?

15) Have you had any bad experiences of vomit or of other people vomiting in front of you or on you?

Yes

No

If yes, please list your past experience(s) of vomit or of others vomiting from the earliest age you can remember. Please use an additional sheet if you need the space.

How old were you?	How distressing is the memory of the experience on a scale of 0-10 (0 is not at all distressing and 10 is severe)?	What were the circumstances surrounding your past experience of vomit or of others vomiting?	Were there any bad consequences of the other person vomiting (e.g. reaction of a relative) or other associations at the time (e.g. other bad events happening in your life?) or a sense that something bad nearly happened because of this experience?

16) How often, on average, do you think a woman vomits from an infection or food-poisoning in your country?

Once every \_\_\_\_\_ month(s) **OR** \_\_\_\_\_ year(s)

17)

How often in the future do you think you will vomit from an infection or food-poisoning?

Once every \_\_\_\_\_ month(s) **OR** \_\_\_\_\_ year(s)

18) How long on average, do you think an episode of vomiting from an infection or food-poisoning would last for in an average woman?

\_\_\_\_\_ minutes **OR** \_\_\_\_\_ hours **OR** \_\_\_\_\_ days

19) If you were to suffer an episode of vomiting caused by infection or food-poisoning how long do you think it would last for?

\_\_\_\_\_ minutes **OR** \_\_\_\_\_ hours **OR** \_\_\_\_\_ days

20) What proportion of women do you think vomit during their first pregnancy?

\_\_\_\_\_ %

21) What proportion of women do you think vomit during the second or third pregnancy?

\_\_\_\_\_ %

22) What proportion of women do you think vomit after a general anaesthetic?

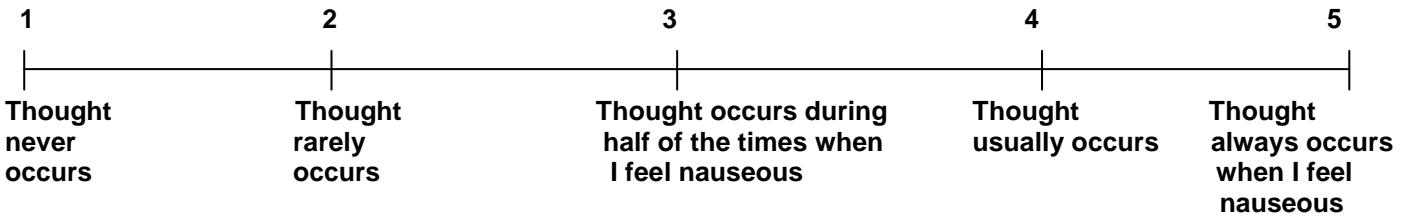
\_\_\_\_\_ %

23) What proportion of women do you think vomit during foreign travel in a third world or emerging country (e.g. India)?

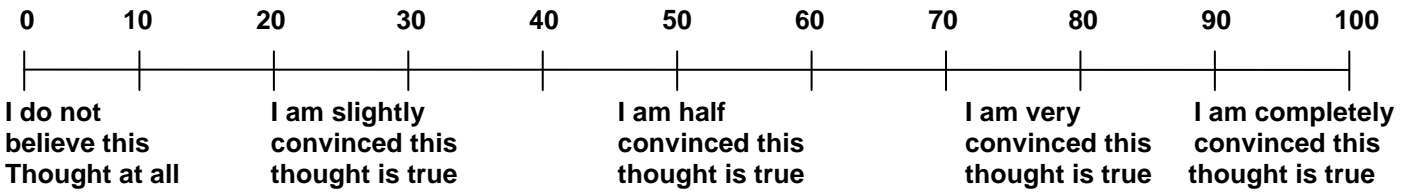
\_\_\_\_\_ %

24) What goes through your mind when you feel nauseous?

a. Please indicate how often you experience each of the thoughts in the following list: rate each thought from 1 to 5 using the scale below; put your rating in the column marked 'OCCURENCE'.



b. When you feel sick, how much do you believe each of the thoughts below to be true? Please rate each thought from 0 to 100 using the scale below; put your rating in the 'BELIEF' column.



Thoughts	Occurrence (Please rate 1-5)	Belief (Please rate 0-100)
I am going to vomit		
I am going to pass out		
I will choke to death		
I am going to act foolishly		
I will lose control		
I will go crazy		
I am going to babble or talk strangely		
I will be paralysed with fear		
I am going to die		
I am seriously ill		
Other - please state		

25) If you thought you might "lose control", can you describe what you think will happen, from the perspective of what others would see and from your own perspective of what you would feel?

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26) How many days a week over the past week have you felt nauseous [at least some of the time]?

\_\_\_\_\_ days during the past week

27) What do you believe is the cause of your nausea?

Please rate the strength of your belief for each of these causes on a scale between 0 -100% where 0% is not at all convinced and 100% is totally convinced.

Cause	Rating 0-100%
Anxiety	
Irritable Bowel Syndrome	
Migraine	
Balance Lean Problem??	
Cancer	
Ulcer or stomach inflammation	
Unknown physical cause	
Other (Pleas specify)_____	



28) Do you do any of the following when you feel sick? Please circle one for each item.

Try to think about other things	Never	Sometimes	Often	Always
Hold on to something tightly	Never	Sometimes	Often	Always
Hold on to or lean on someone	Never	Sometimes	Often	Always
Sit down	Never	Sometimes	Often	Always
Keep still	Never	Sometimes	Often	Always
Move very slowly	Never	Sometimes	Often	Always
Look for an escape route	Never	Sometimes	Often	Always
Make myself do more physical exercise	Never	Sometimes	Often	Always
Focus attention on how I feel physically	Never	Sometimes	Often	Always
Try to keep control of my mind	Never	Sometimes	Often	Always
Try to keep tight control over my vomiting	Never	Sometimes	Often	Always
Talk more	Never	Sometimes	Often	Always
Ask people around for help	Never	Sometimes	Often	Always
Change my breathing	Never	Sometimes	Often	Always
Physically check my body	Never	Sometimes	Often	Always
Eat something	Never	Sometimes	Often	Always
Go to bed	Never	Sometimes	Often	Always
Suck on ice	Never	Sometimes	Often	Always
Read	Never	Sometimes	Often	Always
Suck antacids/mints	Never	Sometimes	Often	Always
Recite a phrase	Never	Sometimes	Often	Always
Reassure myself no-one will vomit (inc me)	Never	Sometimes	Often	Always
Seek reassurance from others	Never	Sometimes	Often	Always
Take medication	Never	Sometimes	Often	Always

What kind of medication do you currently take, how often do you take it and at what dose?

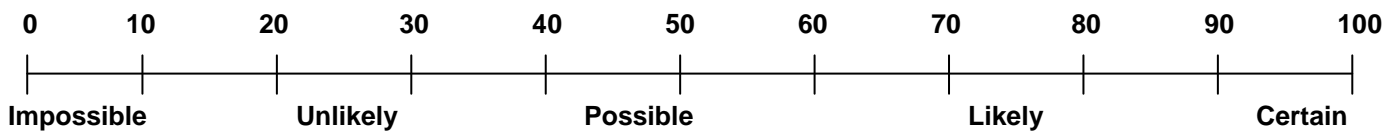
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29) What else do you do if you think you are going to vomit? (Please circle)

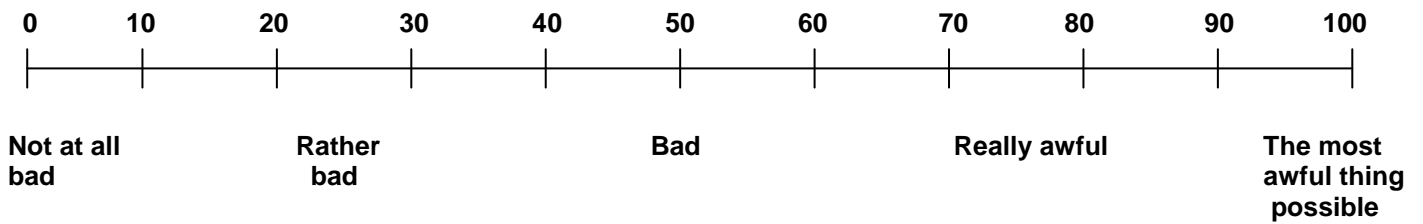
1 _____	Never	Sometimes	Often	Always
2 _____	Never	Sometimes	Often	Always
3 _____	Never	Sometimes	Often	Always
4 _____	Never	Sometimes	Often	Always

30) Please read through the list of consequences that you think might occur after vomiting in the first column of the table.

a) In the second column please rate the likelihood of the consequence occurring if you were to vomit, on a scale between 0 and 100 using the scale below as a guide.



b) In the third column rate how awful the consequence would be if it occurred on a scale between 0 and 100 using the second scale below.



Consequences	Probability of event occurring (0-100: See scale above)	Awfulness if event occurred (0-100: See scale above)
I will lose control		
I will choke		
I will become very ill		
I will die		
I will faint		
I will carry on vomiting for ages		
Others will not want to know me		
Others will find me repulsive		
Other (specify): _____		
Other (specify): _____		

31) In your view, what is the **most awful** aspect of either yourself or others vomiting? Please describe.

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**32) This section is for women only (if you are a man, please go to question Q33)**

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|--|-----|----|
| a) Have you ever been pregnant?  | Yes | No |
| b) If yes, how many times?   | Yes | No |
| c) If yes, did you feel sick during any pregnancy?                     | Yes | No |
| d) If yes, did you vomit during any pregnancy or childbirth?           | Yes | No |
| e) Are you avoiding having children because of a fear of vomiting?     | Yes | No |
| f) Have you ever terminated a pregnancy because of a fear of vomiting? | Yes | No |

**This section is for men. If you are a woman, please go to question 34)**

33) Have you ever placed pressure on a partner to terminate a pregnancy due to your fear of vomiting?

Yes                  No

34) Have you ever avoided an operation with an anaesthetic or a treatment that you have been advised to have because of a fear of vomiting?

Yes                  No

If yes, please describe the situation

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36) Do you **restrict** the amount of food you eat either in the hope of preventing yourself from vomiting or controlling the amount that you vomit? (Please circle)

Never

Sometimes

Often

Always

37) Do you restrict your food for additional reasons (other than a fear of vomiting)? (Please circle)

Never

Sometimes

Often

Always

If yes to either question, please describe what you would eat on a typical day:

Time of day	What do you typically eat?	How much do you restrict what you eat?

38) What is your current weight \_\_\_\_\_ stones \_\_\_\_\_ lbs OR \_\_\_\_\_ kgs

39) What is your current height \_\_\_\_\_ ft \_\_\_\_\_ inches OR \_\_\_\_\_ cms

40) What was your lowest weight at your current height? \_\_\_\_\_ stones \_\_\_\_\_ lbs OR \_\_\_\_\_ kgs

41) Do you excessively smell or check sell by dates of food? (Please circle)

**Never**                      **Sometimes**                      **Often**                      **Always**

If you do, please give details:

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42) Do you check if others are looking or feeling unwell or sick? (Please circle)

**Never**                      **Sometimes**                      **Often**                      **Always**

If you do, please give details:

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43) Do you wash your hands frequently or use special measures (e.g. anti-bacterial soap or very hot water) or wash them for an extra long time? (Please circle)

**Never**                      **Sometimes**                      **Often**                      **Always**

If you do, please give details:

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44) Do you cook your food more than others consider necessary? (Please circle)

**Never**                      **Sometimes**                      **Often**                      **Always**

If you do, please give details:

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45) Do you engage in any rituals (actions that you have to do repeatedly) or counting in an effort to stop yourself vomiting? (please circle)

**Never**

**Sometimes**

**Often**

**Always**

If you do, please give details

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46) Is there anything else you especially look out for or have an urge to check on to prevent the risk of vomiting in yourself or others? If yes, please give details:

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**THIS SECTION IS ONLY FOR THOSE WHO HAVE CHILDREN OR CARE FOR CHILDREN (IF YOU DO NOT, PLEASE GO TO Q48)**

47)a) Do you give medication to your children to stop them from vomiting? (Please circle)

**Never**

**Sometimes**

**Often**

**Always**

If yes, what kind of medication?

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b) Do you restrict their movements? (E.g. going to nursery; visiting friends) (Please circle)

**Never**

**Sometimes**

**Often**

**Always**

If you do, please give details:

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c) Have you ever abandoned a small child if he or she started to vomit? (Please circle)

**Never**

**Sometimes**

**Often**

**Always**

If you do, please give details:

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d) Do you get the children in your care to wash their hands frequently or to use special measures (e.g. anti-bacterial soap or very hot water) or to wash them for an extra long time? (Please circle)

Never                      Sometimes                      Often                      Always

If you do, please give details:

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e) Is your relationship with your children compromised in any other way because of your fear of vomiting? (Please circle)

Never                      Sometimes                      Often                      Always

If you are, please give details:

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**48) PLEASE COMPLETE THIS SECTION IF YOU LIVE WITH A PARTNER OR A CLOSE FRIEND OR RELATIVE (IF NOT, PLEASE GO TO Q49)**

a) Do you seek reassurance from the person/people you live with about whether they look ill or could vomit? If yes, how often? (Please circle)

Never                      Sometimes                      Often                      Always

If you do, please give details:

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b) Do you attempt to restrict their movements or your joint movements? (Please circle)

Never                      Sometimes                      Often                      Always

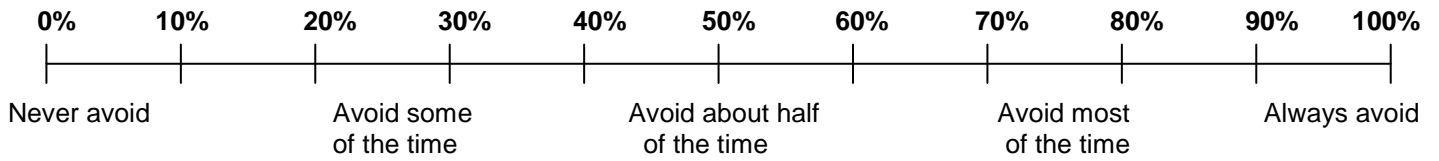
If you do, please give details:

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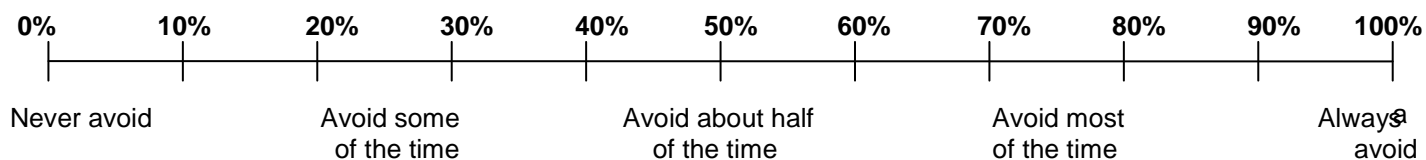


49) Please rate the degree to which you avoid or restrict activities **because** of your fear of vomiting using the scale below.



Activity/Place/ Object avoided because of a fear of vomiting	How much you avoid (0-100%)	Please describe and give details about what you avoid or specific measures you use if you can't avoid it
Public Toilets		
Eating at Restaurants		
Eating from salad bars or buffets		
Eating food that you have not prepared yourself		
Speaking in Public		
Sitting Exams		
Holidays Abroad		
Visiting the Dentist		
Attending an Interview		
Visiting your GP		
Illegal Drugs		
Alcohol		
Crowded Places		
Places where I can't cook for myself		
Drunks		
Pubs		

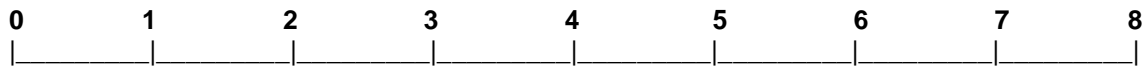
## Avoidance (continued)



Activity/Place/ Object avoided because of a fear of vomiting	How much you avoid (0-100%)	Please describe and give details about what you avoid or specific measures you use if you do can't avoid it
Public Transportation (buses, trains, etc)		
Sea travel by boat		
Travel by aeroplane		
Driving a car		
Being a passenger in a car		
Visiting others who are ill in hospital		
Receiving treatment in hospital		
Adults who are ill or might vomit		
Children or babies who are ill or might vomit		
Certain Films or television programmes		
Fairground Rides		
Places that smell of vomit		
Certain words relating to vomiting (please give details)		If yes, what words do you use?
Foreign holidays (even if the travel was possible)		
Other		

50) If you **have a partner**, please answer 50a. If you do **not** have a partner, please answer 50b.

**a)** To what extent does your fear of vomiting **currently** have an effect on your relationship with an existing partner? (e.g. affectionate feelings, number of arguments, enjoying activities together)



Not at all                      Slightly                      Moderately                      Markedly                      Extremely

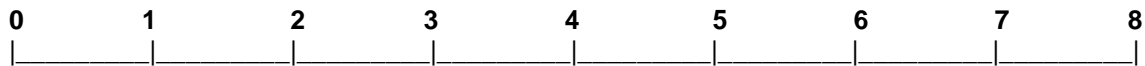
**If so, how does it affect your relationship?**

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**b)** If you do not have a partner, to what extent does your fear of vomiting **currently** have an effect on dating or developing a relationship?



Not at all                      Slightly                      Moderately                      Markedly                      Extremely

**If so, how does it affect your ability to date or have a relationship?**

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51) To what extent does your fear of vomiting **currently** have an effect on a sexual relationship? (e.g. enjoyment of sex, frequency of sexual activity)



Not at all                      Slightly                      Moderately                      Markedly                      Extremely  
I avoid sex

**If so, how?**

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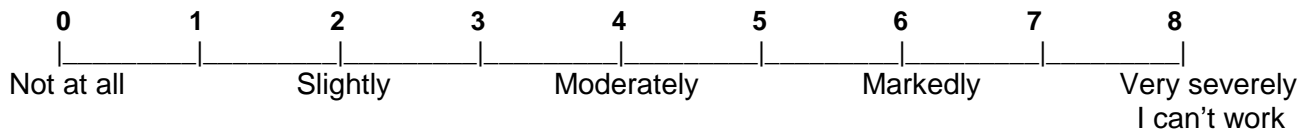


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Tick, if no sexual relationship for reasons other than avoiding sex because of your problem

52) To what extent does your fear of vomiting **currently** interfere with your ability to work or study, or your role as a homemaker? (Please rate this even if you are not working or studying: we are interested in your ability to work or study.)



If so, how does your fear affect it most?

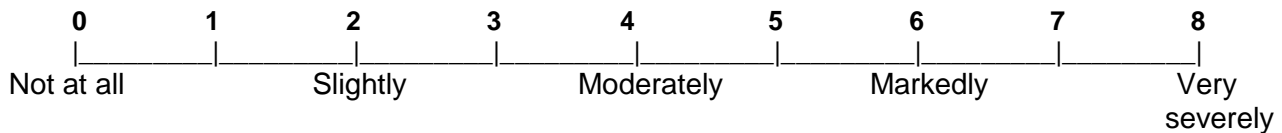
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How many working days have you lost in the past year because of your fear? \_\_\_\_\_

53) To what extent does your fear of vomiting **currently** interfere with your social life? (with other people, e.g. parties, pubs, clubs, outings, visits, home entertainment)



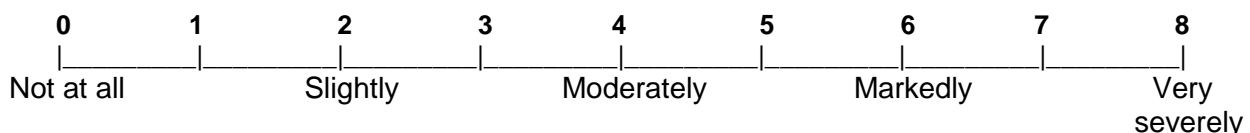
If so, how does it affect it most?

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54) To what extent does your fear of vomiting **currently** interfere with your private leisure activities? (done alone) (e.g. reading; gardening; collecting; walking alone etc)



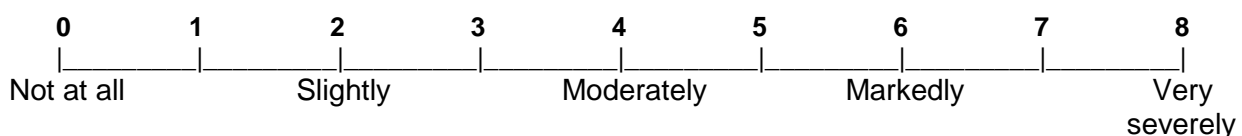
If so, how does it affect it most?

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55) To what extent does your fear of vomiting **currently** interfere with your home management? (e.g. cleaning, tidying, shopping, cooking, looking after your home or children, paying bills etc)



If so, how does it affect it most?

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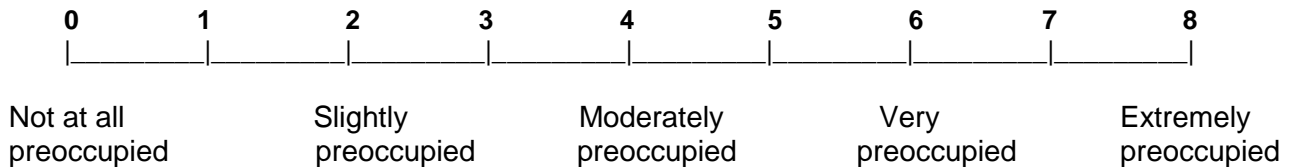


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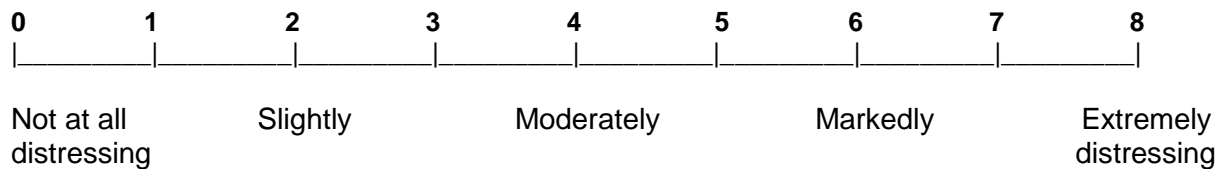
56) On an average day over the past week, how much time do you spend worrying about yourself or others vomiting? (This includes thinking about how to prevent it)

\_\_\_\_\_ minutes OR \_\_\_\_\_ hours a day

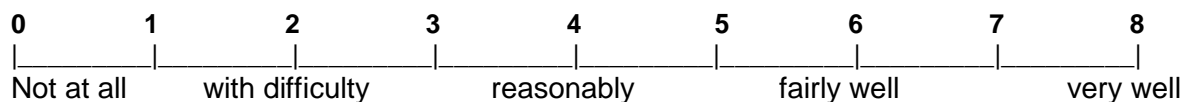
57) To what extent does your worry about vomiting preoccupy you over the past week? That is, you think about it a lot and it is hard to stop thinking about it?



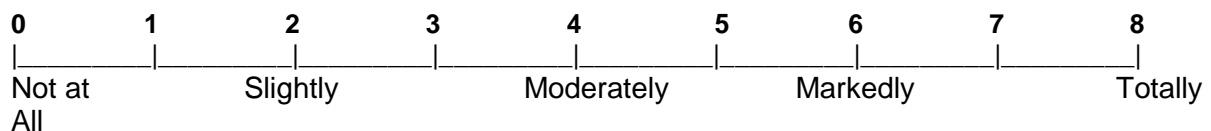
58) How distressing has your fear of vomiting been in the past week?



59) How well do you think you would cope with an episode of vomiting in the future?

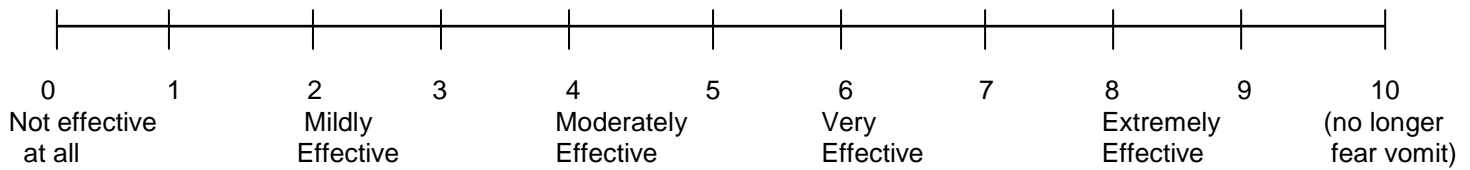


60) To what extent do you believe you can influence or prevent yourself vomiting from any cause in the future?



61) This next section is for treatments that you have had for your fear of vomiting.

Please rate the effectiveness of each therapy that you received using the scale below.



a) Have you had behaviour therapy (exposure) or cognitive behaviour therapy?

Yes No

If yes, please give details about what it consisted of, when and by whom it was delivered and how effective it was using the scale above?

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b) Have you ever been prescribed and taken any psychiatric medication for your fear of vomiting?

Yes No

If yes, please give name of medication and dosage, with the dates when you took it, and say how effective it was.

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c) Have you had any other types of therapy (e.g. hypnotherapy) for your fear of vomiting?

Yes No

If yes, please describe what it consisted of and give details and how effective it was?

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