

MENTAL HEALTH AMONG MEDICAL STUDENTS OF NEPAL
CONSENT FORM

Dear Participant,

We invite you to participate in a research study entitled ‘Mental Health among Medical Students of Nepal.’ The purpose of the research is to determine the prevalence of mental disorders among medical students. The enclosed questionnaire has been designed to collect information on symptoms of somatoform disorder, depression, anxiety, eating disorder, smoking and Marijuana use.

Your participation in this research project is completely voluntary. You may decline altogether, or leave blank any questions you don’t wish to answer. There are no known risks or discomforts associated with this survey. Your responses will be kept strictly confidential, and digital data will be stored in secure computer files after it is entered. Data from this research will be reported only as a collective combined total. Any report of this research that is made available to the public will not include your name or any other individual information by which you could be identified.

If you agree to participate in this project, please answer the questions on the questionnaire as best you can. It should take approximately 15 minutes to complete. Please return the questionnaire as soon as possible. If you have any questions about this project, feel free to contact Arjab Adhikari at docarjab@gmail.com. Information on the rights of human subjects in research is available through the Institutional Review Board of KIST Medical College Teaching Hospital. Email: irbkistmc@gmail.com

Completing this survey indicates that you are 18 years of age or older and indicates your consent to participate in the research.

Thank you for your assistance in this important endeavor.

Sincerely yours,

Arjab Adhikari, MBBS (Principal investigator)



How Are We Doing?

Please take a few minutes to fill out this survey. Your answers will be kept confidential. Thank you for your participation.

Socio-Demographic Information

Age :

Gender: Male Female

Year of Medical School: First Second Third Fourth

Where do you stay?: At Home Rented Room Hostel Others (Specify) _____

Personal Information

Relationship Problem in family/friends: Yes No

Mental Disorders in family: Yes No

Dissatisfaction with your Academic Performance: Yes No

High parental expectations: Yes No

Dissatisfaction with career choice: Yes No

Lack of opportunities for leisure activities: Yes No

PATIENT HEALTH QUESTIONNAIRE (PHQ)

1. During the last 4 weeks, how much have you been bothered by any of the following problems?	Not bothered	Bothered a little	Bothered a lot
a. Stomach pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Pain in your arms, legs, or joints (knees, hips, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Menstrual cramps or other problems with your periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Pain or problems during sexual intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Feeling your heart pound or race	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Constipation, loose bowels, or diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Nausea, gas, or indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Thoughts that you would be better off dead or of hurting yourself in some way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Questions about anxiety.

	NO	YES
a. In the last 4 weeks, have you had an anxiety attack — suddenly feeling fear or panic?	<input type="checkbox"/>	<input type="checkbox"/>
If you checked "NO", go to question #5.		
b. Has this ever happened before?	<input type="checkbox"/>	<input type="checkbox"/>
c. Do some of these attacks come suddenly out of the blue — that is, in situations where you don't expect to be nervous or uncomfortable?	<input type="checkbox"/>	<input type="checkbox"/>
d. Do these attacks bother you a lot or are you worried about having another attack?	<input type="checkbox"/>	<input type="checkbox"/>

4. Think about your last bad anxiety attack.

	NO	YES
a. Were you short of breath?	<input type="checkbox"/>	<input type="checkbox"/>
b. Did your heart race, pound, or skip?	<input type="checkbox"/>	<input type="checkbox"/>
c. Did you have chest pain or pressure?	<input type="checkbox"/>	<input type="checkbox"/>
d. Did you sweat?	<input type="checkbox"/>	<input type="checkbox"/>
e. Did you feel as if you were choking?	<input type="checkbox"/>	<input type="checkbox"/>
f. Did you have hot flashes or chills?	<input type="checkbox"/>	<input type="checkbox"/>
g. Did you have nausea or an upset stomach, or the feeling that you were going to have diarrhea?	<input type="checkbox"/>	<input type="checkbox"/>
h. Did you feel dizzy, unsteady, or faint?	<input type="checkbox"/>	<input type="checkbox"/>
i. Did you have tingling or numbness in parts of your body?...	<input type="checkbox"/>	<input type="checkbox"/>
j. Did you tremble or shake?	<input type="checkbox"/>	<input type="checkbox"/>
k. Were you afraid you were dying?	<input type="checkbox"/>	<input type="checkbox"/>

5. Over the last 4 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days
a. Feeling nervous, anxious, on edge, or worrying a lot about different things.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If you checked "Not at all", go to question #6.			
b. Feeling restless so that it is hard to sit still.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Getting tired very easily.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Muscle tension, aches, or soreness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Trouble falling asleep or staying asleep.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Trouble concentrating on things, such as reading a book or watching TV.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Becoming easily annoyed or irritable.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. Questions about eating.			
a.	Do you often feel that you can't control <u>what</u> or <u>how much</u> you eat?	NO <input type="checkbox"/>	YES <input type="checkbox"/>
b.	Do you often eat, <u>within any 2-hour period</u> , what most people would regard as an unusually <u>large</u> amount of food?	<input type="checkbox"/>	<input type="checkbox"/>
If you checked "NO" to either #a or #b, go to question #9.			
c.	Has this been as often, on average, as twice a week for the last 3 months?	<input type="checkbox"/>	<input type="checkbox"/>
7. In the last 3 months have you <u>often</u> done any of the following in order to avoid gaining weight?		NO	YES
a.	Made yourself vomit?	<input type="checkbox"/>	<input type="checkbox"/>
b.	Took more than twice the recommended dose of laxatives?	<input type="checkbox"/>	<input type="checkbox"/>
c.	Fasted — not eaten anything at all for at least 24 hours?	<input type="checkbox"/>	<input type="checkbox"/>
d.	Exercised for more than an hour specifically to avoid gaining weight after binge eating?	<input type="checkbox"/>	<input type="checkbox"/>
8. If you checked "YES" to any of these ways of avoiding gaining weight, were any as often, on average, as twice a week?		NO <input type="checkbox"/>	YES <input type="checkbox"/>
9. Do you ever drink alcohol (including beer or wine)?		NO <input type="checkbox"/>	YES <input type="checkbox"/>
If you checked "NO" go to question #11.			
10. Have any of the following happened to you <u>more than once in the last 6 months</u>?		NO	YES
a.	You drank alcohol even though a doctor suggested that you stop drinking because of a problem with your health.	<input type="checkbox"/>	<input type="checkbox"/>
b.	You drank alcohol, were high from alcohol, or hung over while you were working, going to school, or taking care of children or other responsibilities.	<input type="checkbox"/>	<input type="checkbox"/>
c.	You missed or were late for work, school, or other activities because you were drinking or hung over.	<input type="checkbox"/>	<input type="checkbox"/>
d.	You had a problem getting along with other people while you were drinking.	<input type="checkbox"/>	<input type="checkbox"/>
e.	You drove a car after having several drinks or after drinking too much.	<input type="checkbox"/>	<input type="checkbox"/>
11. If you checked off <u>any</u> problems on this questionnaire, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?			
Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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About Smoking

Do you Smoke: Yes No

If you check “**NO**” then continue to next block

When did you start smoking?

Before Joining Medical School

After Joining Medical School

If you started before joining medical school, did it increase or decrease after joining medical school?

Increase

Decrease

About Marijuana use

Before Medical School

- No use
- 1 – 10 times
- More than 10 times but less than each month
- Each month but less than each week
- Each week but not daily
- Daily

During Medical School

- No use
- 1 – 10 times
- More than 10 times but less than each month
- Each month but less than each week
- Each week but not daily
- Daily

Suicidal Ideation

Have you seriously considered committing suicide while in medical school?

Yes

No

Dropping Out

Have you considered dropping out of medical school during past month?

Yes

No

Thank you for completing our survey.