# INTRODUCTION

Obesity has become a global epidemic in both developed and developing countries over the last few decades. Approximately 10–15% of all obese people become obese during adolescence. In the USA, there is an increasing frequency of hospital discharges of obesity-associated diagnoses in children and adolescents ***(Elishkevits et al., 2005).***

An increased prevalence of overweight and obesity has been reported in many developed countries over the past decades. Moreover, there is growing evidence that excess weight is causally related to chronic diseases and all-cause mortality. Obesity is associated with an increased risk of hypertension, non-insulin-dependent diabetes mellitus, hyperlipidaemia and other chronic diseases ***(Padez, 2006).***

Obesity is a multifactorial problem and its development is due to multiple interactions between genes and the environment ***(Padez, 2006).***

Obesity has a great impact on health related quality of life (HRQL). In recent years awareness has increased of the importance of including HRQL in clinical assessments. For many clinicians HRQL is a new term but certainly not a new concept. The questionnaires provide a standardized quantified and recorded summary of the problems. Patients themselves considered important ***(Juniper, 1997).***

Obesity has been associated with impaired quality of life (QOL) in a variety of domains including physical functioning, public distress, sexual functioning, self-esteem and work-related QOL. A number of factors may influence the relationships among obesity, psychosocial functioning and QOL. These factors include race, gender and degree of overweight ***(White et al., 2004)***.