



Study #021

Plate #030

Seq #003

Participant ID # - -

Today's Date
 day month year

Baseline Questionnaire
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Demographics

1. Age: years
2. Gender: Female Male
3. What is your highest level of schooling or education?

<input type="checkbox"/> Primary or grammar school	<input type="checkbox"/> Some college or university education
<input type="checkbox"/> Some high school	<input type="checkbox"/> Graduated from college or university
<input type="checkbox"/> Graduated from high school	<input type="checkbox"/> None
4. Which of the following best describes your current employment status?

<input type="checkbox"/> Working full-time	<input type="checkbox"/> Student
<input type="checkbox"/> Working part-time	<input type="checkbox"/> Temporarily not working
<input type="checkbox"/> Homemaker full-time	<input type="checkbox"/> Unable to work because of health reasons and/or disabled
<input type="checkbox"/> Retired	

Ethnic Background

5. What is your ethnicity? **Mark all that apply.**

<input type="checkbox"/> Caucasian	<input type="checkbox"/> Asian or Pacific Islander
<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> African-American, Afro-Caribbean or other African Heritage
<input type="checkbox"/> Native American	



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6. Please mark the ethnic origins of all of your biological grandparents (father's father, father's mother, mother's father, and mother's mother). **Mark all that apply.**

- | | |
|--|--|
| <input type="checkbox"/> Northern European | <input type="checkbox"/> Caribbean |
| <input type="checkbox"/> Central European | <input type="checkbox"/> South American |
| <input type="checkbox"/> Southern European | <input type="checkbox"/> Latin American Indian |
| <input type="checkbox"/> Eastern European | <input type="checkbox"/> Chinese (Han) |
| <input type="checkbox"/> Middle Eastern | <input type="checkbox"/> Chinese (Non-Han) |
| <input type="checkbox"/> East Mediterranean | <input type="checkbox"/> Japanese |
| <input type="checkbox"/> North African | <input type="checkbox"/> Korean |
| <input type="checkbox"/> Sub-Saharan African | <input type="checkbox"/> Filipino |
| <input type="checkbox"/> North American | <input type="checkbox"/> South-East Asian |
| <input type="checkbox"/> North American Indian | <input type="checkbox"/> Indian sub-continent |
| <input type="checkbox"/> Mexican | <input type="checkbox"/> Other |
| <input type="checkbox"/> Central American | |

Tobacco Use History

7. Do you currently smoke cigarettes? ^{yes} ^{no} → **Go to item 10**
8. Have you ever smoked cigarettes? ^{yes} ^{no} → **Go to item 12**
9. At what age did you stop smoking? years
10. At what age did you start smoking? years
11. Approximately how many cigarettes a day do/did you smoke? cigarettes Less than 1 cigarette per day
12. Do you use any other forms of tobacco? ^{yes} ^{no} → **Go to item 13**

12a. Which of the following forms of tobacco do you use? **Mark all that apply.**

- Cigars Pipe Smokeless or chewing tobacco



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13. Do you use any other forms of nicotine?

yes

no

➔ **Go to item 14**

13a. Which of the following forms of nicotine do you use? **Mark all that apply.**

Patch

Chewing gum

Other

General Physical and Emotional Health

These next questions are about your health now and your current daily activities. Please try to answer each question as accurately as you can.

*14. In general, would you say your health is:

Excellent

Very Good

Good

Fair

Poor

*The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

*15. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf

Yes,
limited a lot

Yes,
limited a little

No,
not limited at all

*16. Climbing several flights of stairs.

*During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

*17. Accomplished less than you would like

	<i>All of the time</i>	<i>Most of the time</i>	<i>Some of the time</i>	<i>A little of the time</i>	<i>None of the time</i>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*18. Were limited in the kind of work or other activities.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------	--------------------------



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*During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

- | | <i>All of the time</i> | <i>Most of the time</i> | <i>Some of the time</i> | <i>A little of the time</i> | <i>None of the time</i> |
|--|--------------------------|--------------------------|--------------------------|-----------------------------|--------------------------|
| *19. <u>Accomplished less</u> than you would like | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| *20. Did work or other activities <u>less carefully than usual</u> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

*21. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

- | | |
|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Not at all | <input type="checkbox"/> Quite a bit |
| <input type="checkbox"/> A little bit | <input type="checkbox"/> Extremely |
| <input type="checkbox"/> Moderately | |

*These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks...

- | | <i>All of the time</i> | <i>Most of the time</i> | <i>Some of the time</i> | <i>A little of the time</i> | <i>None of the time</i> |
|---|--------------------------|--------------------------|--------------------------|-----------------------------|--------------------------|
| *22. Have you felt calm and peaceful? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| *23. Did you have a lot of energy? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| *24. Have you felt downhearted and depressed? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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*25. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

- All of the time
- A little bit of the time
- Most of the time
- None of the time
- Some of the time

Over the last 2 WEEKS how often have you felt bothered by the following problems:

26. Little interest or pleasure doing things

- Not at all
- More than half the days
- Several days
- Nearly every day

27. Feeling down, depressed or hopeless

- Not at all
- More than half the days
- Several days
- Nearly every day

28. Trouble falling or staying asleep, or sleeping too much

- Not at all
- More than half the days
- Several days
- Nearly every day

29. Feeling tired or having little energy

- Not at all
- More than half the days
- Several days
- Nearly every day

30. Poor appetite or overeating

- Not at all
- More than half the days
- Several days
- Nearly every day

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31. Feeling bad about yourself, or that you are a failure or have let yourself or your family down

- Not at all
- Several days
- More than half the days
- Nearly every day

32. Trouble concentrating on things, such as reading the newspaper or watching television

- Not at all
- Several days
- More than half the days
- Nearly every day

33. Moving or speaking so slow 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

- Not at all
- Several days
- More than half the days
- Nearly every day

34. Thoughts that you would be better off dead, or of hurting yourself in some way

- Not at all
- Several days
- More than half the days
- Nearly every day

Reproductive and Hormonal History

To be completed by women only. Men go to item 44.

35. How old were you when you first began having you menstrual period? years

yes no

36. Have you started or experienced menopause? → **Go to item 38**

37. How old were you at the start of menopause? years

yes no

38. Have you had significant vaginal dryness?

39. How many times have you been pregnant in your lifetime? → **If 0, go to item 42**
 Please include live births, still births, terminations/abortions, miscarriages and tubal pregnancies.



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40. How many of these pregnancies resulted in:

- 40a. Full-term delivery?
- 40b. Premature delivery (more than 3 weeks before due date)?
- 40c. Miscarriage during the 1st trimester?
- 40d. Miscarriage during the 2nd trimester?
- 40e. Stillbirth during the 3rd trimester?

yes no

41. Have you ever had a child born with complete congenital heart block?

yes no

42. Do you currently take female hormones (birth control pills, estrogen and/or
 progestins as pills, patches or injections, etc.)?

yes no

43. Have you had a hysterectomy?

yes no

44. Does your mouth feel dry?

▶ Go to
 item 45

44a. When does your mouth feel dry? **Mark all that apply.**

- In the morning
- In the afternoon
- At night

44b. When did your mouth first start feeling dry?
 month year

yes no

45. Does your mouth feel dry when eating a meal?

yes no

46. Do you have difficulty swallowing any foods?

yes no

47. Do you need to sip liquids to swallow dry foods?



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48. Is the amount of saliva in your mouth:

- Too little Too much You don't notice it

49. How often do you use artificial saliva?

- 10 times a day or more 1 to 3 times a day
 4 to 9 times a day Never

50. Can you eat a cracker without drinking a fluid/liquid? *yes* *no*

51. Do you have a burning sensation on your tongue or in other parts of your mouth? . . . *yes* *no*

→ **Go to item 52**

51a. In which parts of your mouth do you have a burning sensation? **Mark all that apply.**

- Tongue Cheeks
 Palate (roof of mouth) Gums
 Lips Entire mouth

52. How would you describe your dental and oral health in general?

- Excellent Good Fair Poor

53. In general, how often do you brush your teeth?

- Never Occasionally Once per day Twice per day Three times per day or more

54. In general, how often do you floss your teeth?

- Never Occasionally Once per day More than once a day

55. How often do you clean between your teeth with a toothpick?

- Never Occasionally Once per day More than once a day

56. In the past year, have you avoided eating certain foods you wanted because *yes* *no*
 they made your mouth hurt?



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57. Have you experienced any change/loss in your sense of taste? *yes* *no*

58. Do you have a regular source of dental care - that is, a dentist or dental clinic that you visit on a regular basis to get your teeth examined, cleaned, or cared for? *yes* *no*

59. About how long has it been since you were last treated or examined by a dentist or a hygienist?

- Less than 3 months
- 3 to 6 months
- 6 to 12 months
- 1-2 years
- 2-3 years
- 3-5 years
- More than 5 years
- Never

60. Approximately how many times have you visited the dentist in the past year?

- 0
- 1
- 2
- 3
- 4
- 5
- 6 or more

61. During the past 12 months have you had any of the following dental procedures?

Mark all that apply.

- Oral examination
- Radiographs or x-rays of the teeth
- Teeth cleaned by a dentist or hygienist
- A tooth filled or crown made
- Orthodontic treatment or braces
- Any gum treatment or gum surgery
- A tooth or teeth removed
- A biopsy taken from your mouth or lip
- None

Symptoms Affecting Your Eyes

62. Do your eyes feel dry? *yes* *no*

62a. When do your eyes feel dry? **Mark all that apply.**

- In the morning
- In the afternoon
- At night

Go to item 63

62b. When did your eyes first start feeling dry? [][] [][]
month year



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- | | <i>None
of the
time</i> | <i>Some
of the
time</i> | <i>Half of
the time</i> | <i>Most
of the
time</i> | <i>All of
the
time</i> |
|---|---------------------------------|---------------------------------|-----------------------------|---------------------------------|--------------------------------|
| 63. How often do you have redness in your eyes? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 64. How often do your eyes itch? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 65. How often do you have excessive tears? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 66. Are you able to produce tears? | <input type="checkbox"/> | <input type="checkbox"/> | | | |

67. How often do you use artificial tears?

- | | |
|---|---|
| <input type="checkbox"/> 10 times a day or more | <input type="checkbox"/> 1 to 3 times a day |
| <input type="checkbox"/> 4 to 9 times a day | <input type="checkbox"/> Never → Go to item 68 |

67a. What type of artificial tears do you use? **Mark all that apply.**

- | | | | |
|--|--|-----------------------------------|-------------------------------------|
| <input type="checkbox"/> Bottles
(with preservatives) | <input type="checkbox"/> Single vials (without
preservatives) | <input type="checkbox"/> Ointment | <input type="checkbox"/> Don't know |
|--|--|-----------------------------------|-------------------------------------|

67b. Does your vision improve with artificial tears?

<input type="checkbox"/>	<input type="checkbox"/>
<i>yes</i>	<i>no</i>

68. Do you use any other type of medicated drops in your eyes? → **Go to item 69**

68a. What type of medicated drops do you use? **Mark all that apply.**

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> Whitening/
vasoconstrictor | <input type="checkbox"/> Cyclosporine/
restasis | <input type="checkbox"/> Traditional |
| <input type="checkbox"/> Antibiotic | <input type="checkbox"/> Steroid | <input type="checkbox"/> Other |

69. During the LAST WEEK have you experienced any of the following symptoms with your eyes:

	<i>None of the time</i>	<i>Some of the time</i>	<i>Half of the time</i>	<i>Most of the time</i>	<i>All of the time</i>
--	---------------------------------	---------------------------------	-----------------------------	---------------------------------	--------------------------------

- | | | | | | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 69a. Light sensitivity | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 69b. Gritty or scratchy sensation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 69c. Burning or stinging | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |



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- | | <i>None of the time</i> | <i>Some of the time</i> | <i>Half of the time</i> | <i>Most of the time</i> | <i>All of the time</i> | |
|--|----------------------------------|--------------------------------------|---------------------------------|--------------------------------|--------------------------------|--------------------------|
| 69d. Blurred vision. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 69e. Vision that fluctuates with blinking. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 69f. Tearing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 69g. Pain or burning in the middle of the night or upon . . .
waking in the morning | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 70. Have you experienced eye irritation while performing any of these activities during the last week: | <i>None of the time</i> | <i>Some of the time</i> | <i>Half of the time</i> | <i>Most of the time</i> | <i>All of the time</i> | <i>Not applicable</i> |
| 70a. Reading or driving a car for a long period . . . | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 70b. Watching TV or working on a computer for . . .
an extended period | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 71. Have your eyes felt uncomfortable in any of the following situations during the last week | <i>None of the time</i> | <i>Some of the time</i> | <i>Half of the time</i> | <i>Most of the time</i> | <i>All of the time</i> | |
| 71a. Wind or air drafts | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 71b. Places with low humidity such as air conditioned or . . .
heated buildings or airplanes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 72. Have any of your immediate blood related family members
(see below) been diagnosed with Sjögren's Syndrome? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 72a. Which family member(s)? Mark all that apply. | <input type="checkbox"/> Mother | <input type="checkbox"/> Son | <input type="checkbox"/> Aunt | <input type="checkbox"/> Niece | <input type="checkbox"/> Other | |
| | <input type="checkbox"/> Father | <input type="checkbox"/> Daughter | <input type="checkbox"/> Uncle | | | |
| | <input type="checkbox"/> Sister | <input type="checkbox"/> Grandmother | <input type="checkbox"/> Cousin | | | |
| | <input type="checkbox"/> Brother | <input type="checkbox"/> Grandfather | <input type="checkbox"/> Nephew | | | |

Go to
**Baseline
 Medical
 History
 Questionnaire**

CLINIC USE ONLY	yes	no
73. Was this questionnaire administered by study staff?	<input type="checkbox"/>	<input type="checkbox"/>