



Study #021

Plate #050

Seq #003

Participant ID # [ ][ ] - [ ][ ][ ][ ] - [ ][ ]

Today's Date [ ][ ] [ ][ ] [ ][ ]  
day month year

Baseline Medical History Questionnaire

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MEDICAL HISTORY

Do you currently have a diagnosis (made by a physician) of any of the following (if you do not recognize the name of any of the following conditions, you most likely have never been diagnosed with it):

- |  | <i>yes</i>               | <i>no</i>                |
|--|--------------------------|--------------------------|
| 1. Type 1 Diabetes (Insulin dependent) .....     | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Type 2 Diabetes (Non-insulin dependent) ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Multiple Sclerosis .....                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Behçet's Disease .....                        | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Psoriasis .....                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Myasthenia Gravis .....                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Vitiligo .....                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Pemphigus Vulgaris .....                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Ulcerative Colitis .....                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Crohn's Disease .....                        | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Wegener's Granulomatosis .....               | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Discoid Lupus .....                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Ankylosing Spondylitis .....                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Pernicious or Hemolytic Anemia .....         | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Graves' Disease .....                        | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Hashimoto's Thyroiditis .....                | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Reiter's Syndrome .....                      | <input type="checkbox"/> | <input type="checkbox"/> |



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**Baseline Medical History Questionnaire**  
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**SYSTEMS REVIEW**

Please indicate whether or not the following symptoms have significantly affected you in the last year (symptoms occurring at a greater frequency or severity than you would expect for your age):

**Constitutional** yes no  
 18. Unintentional weight loss over 10 pounds/4.5 kilograms in the last year. . . . .

**Ears, Nose and Throat** yes no

19. Ringing in ears. . . . .

20. Loss of hearing . . . . .

21. Nosebleeds . . . . .

22. Loss of smell . . . . .

23. Dryness in nose. . . . .

24. Loss of taste . . . . .

25. Hoarse voice without a cold. . . . .

**Respiratory** yes no

26. Frequent coughing without a cold . . . . .

27. Coughing of blood . . . . .

28. Wheezing (asthma) . . . . .

29. An abnormal chest x-ray . . . . .

30. Shortness of breath . . . . .

31. Awakening at night with shortness of breath . . . . .



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**Baseline Medical History Questionnaire**  
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Please indicate whether or not the following symptoms have significantly affected you in the last year (symptoms occurring at a greater frequency or severity than you would expect for your age):

- 32. Discomfort, pressure, a tight feeling, or pain in the chest .....  *yes*  *no*
- 33. Cramps in your legs while walking .....  *yes*  *no*

**Gastrointestinal**

- 34. Nausea .....  *yes*  *no*
- 35. Vomiting of blood or coffee ground material .....  *yes*  *no*
- 36. Frequent or severe heartburn .....  *yes*  *no*
- 37. Stomach pain relieved by food or milk .....  *yes*  *no*
- 38. Jaundice .....  *yes*  *no*
- 39. Increasing constipation .....  *yes*  *no*
- 40. Persistent diarrhea .....  *yes*  *no*
- 41. Blood in stools .....  *yes*  *no*

**Genitourinary**

- 42. Getting up at night to pass urine .....  *yes*  *no*

**Musculoskeletal**

- 43. Joint stiffness in the morning, lasting for more than one hour .....  *yes*  *no*
- 44. Joint pain or joint swelling .....  *yes*  *no*
- 45. Unexplained pain in many areas of both your upper and lower body and both your right and left sides that lasted 3 months or more .....  *yes*  *no*



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**Baseline Medical History Questionnaire**  
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Please indicate whether or not the following symptoms have significantly affected you in the last year (symptoms occurring at a greater frequency or severity than you would expect for your age):

**Skin**

yes no

46. Easy bruising .....

47. Redness .....

48. Rash .....

49. Hives (itchy welts caused by allergic reaction) .....

50. Sun sensitivity (significant rash after sun exposure, but not sun burn) .....

51. Tightness .....

52. Hair loss .....

53. Color changes of fingers or toes when exposed to the cold (Raynaud's) .....

**Neurological**

yes no

54. Dizziness .....

55. Memory loss .....

56. Recurring severe headaches .....

57. Fainting or blackout spells .....

**Upper Limbs**

Do you experience these symptoms to an abnormal degree in one or both sides of your body?

yes no

58. Weakness of hands (e.g. to zip, button, handle coins, manipulate a key, .....    
 or other hand weakness)

59. Weakness of fingers when clasping or grasping objects .....



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Baseline Medical History Questionnaire  
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Please indicate whether or not the following symptoms have significantly affected you in the last year (symptoms occurring at a greater frequency or severity than you would expect for your age):

60. Weakness of shoulders and upper arms, for example, to lift objects from a high shelf, to comb your hair, or to bring your hands to your face as in washing or eating yes no

Lower Limbs

Do you experience these symptoms to an abnormal degree in one or both sides of your body?

61. Weakness of the legs so that you slap your feet in walking or cannot carry your weight on your heels yes no

62. Weakness of the legs so that you cannot walk on your toes or forefoot

63. Weakness of your thighs and hips so that you have difficulty (or inability) to climb or descend stairs, arise from a chair, sofa or toilet seat, and in these acts need to use your arms

Sensory Symptoms

Do you experience these symptoms in one region or over the surface of your body to an abnormal degree? Do not include the brief symptoms of "prickling" or "asleep numbness" and discomfort which come from lying too long on an arm, or sitting or lying too long in one position on a leg.

64. Decrease (or inability) to feel the surface features, size, shape, or texture of what you touch yes no  
  → Go to item 65

64a. Mark all that apply:

- In legs (feet are included)
- In mouth, face, or head
- In arms (hands are included)
- In other parts of the body

65. Decrease (or inability) to recognize hot from cold yes no  
  → Go to item 66

65a. Mark all that apply:

- In legs (feet are included)
- In mouth, face, or head
- In arms (hands are included)
- In other parts of the body



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**Baseline Medical History Questionnaire**  
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Please indicate whether or not the following symptoms have significantly affected you in the last year (symptoms occurring at a greater frequency or severity than you would expect for your age):

66. Decrease (or inability) to feel pain, cuts, bruises, or injuries. . . . .  <sup>yes</sup>  <sup>no</sup> → **Go to item 67**

66a. **Mark all that apply:**

- In legs (feet are included)  In mouth, face, or head
- In arms (hands are included)  In other parts of the body

67. A more or less continuous "prickling" or "tingling" feeling with or without . . . . .  <sup>yes</sup>  <sup>no</sup> → **Go to item 68**  
an asleep dead feeling

67a. **Mark all that apply:**

- In legs (feet are included)  In mouth, face, or head
- In arms (hands are included)  In other parts of the body

68. Sharp "jabbing" needle-like pain or pulses of pain . . . . .  <sup>yes</sup>  <sup>no</sup> → **Go to item 69**  
(lasting seconds or a minute or two)

68a. **Mark all that apply:**

- In legs (feet are included)  In mouth, face, or head
- In arms (hands are included)  In other parts of the body

69. Persistent or frequent burning discomfort . . . . .  <sup>yes</sup>  <sup>no</sup> → **End of Questionnaire**

69a. **Mark all that apply:**

- In legs (feet are included)  In mouth, face, or head
- In arms (hands are included)  In other parts of the body

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