

5. Please check (✓) if you have experienced any of the following over the last month:

- | | | |
|---|--|---|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Lump in your throat | <input type="checkbox"/> Paralysis of arms or legs |
| <input type="checkbox"/> Weight gain (>10 lbs) | <input type="checkbox"/> Cough | <input type="checkbox"/> Numbness or tingling of arms or legs |
| <input type="checkbox"/> Weight loss (>10 lbs) | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Fainting spells |
| <input type="checkbox"/> Feeling sickly | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Swelling of hands |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pain in the chest | <input type="checkbox"/> Swelling of ankles |
| <input type="checkbox"/> Unusual fatigue | <input type="checkbox"/> Heart pounding (palpitations) | <input type="checkbox"/> Swelling in other joints |
| <input type="checkbox"/> Swollen glands | <input type="checkbox"/> Trouble swallowing | <input type="checkbox"/> Joint pain |
| <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Heartburn or stomach gas | <input type="checkbox"/> Back pain |
| <input type="checkbox"/> Skin rash or hives | <input type="checkbox"/> Stomach pain or cramps | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> Unusual bruising or bleeding | <input type="checkbox"/> Nausea | <input type="checkbox"/> Use of drugs not sold in stores |
| <input type="checkbox"/> Other skin problems | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Smoking cigarettes |
| <input type="checkbox"/> Loss of hair | <input type="checkbox"/> Constipation | <input type="checkbox"/> More than 2 alcoholic drinks per day |
| <input type="checkbox"/> Dry eyes | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Depression - feeling blue |
| <input type="checkbox"/> Other eye problems | <input type="checkbox"/> Dark or bloody stools | <input type="checkbox"/> Anxiety - feeling nervous |
| <input type="checkbox"/> Problems with hearing | <input type="checkbox"/> Problems with urination | <input type="checkbox"/> Problems with thinking |
| <input type="checkbox"/> Ringing in the ears | <input type="checkbox"/> Gynecological (female) problems | <input type="checkbox"/> Problems with memory |
| <input type="checkbox"/> Stuffy nose | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Problems with sleeping |
| <input type="checkbox"/> Sores in the mouth | <input type="checkbox"/> Losing your balance | <input type="checkbox"/> Sexual problems |
| <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Muscle pain, aches, or cramps | <input type="checkbox"/> Burning in sex organs |
| <input type="checkbox"/> Problems with smell or taste | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Problems with social activities |

FOR OFFICE USE ONLY

5. ROS:

Please check (✓) here if you have had none of the above over the last month: _____.

6. When you awakened in the morning OVER THE LAST WEEK, did you feel stiff? No Yes

If "No," please go to Item 7. If "Yes," please indicate the number of minutes _____, or hours _____ until you are as limber as you will be for the day.

7. How do you feel TODAY compared to ONE WEEK AGO? Please check (✓) only one.

Much Better (1), Better (2), the Same (3), Worse (4), Much Worse (5) than one week ago

8. How often do you exercise aerobically (sweating, increased heart rate, shortness of breath) for at least one-half hour (30 minutes)? Please check (✓) only one.

- 3 or more times a week (3) 1-2 times per month (1)
 1-2 times per week (2) Do not exercise regularly (0) Cannot exercise due to disability/ handicap (9)

9. How much of a problem has UNUSUAL fatigue or tiredness been for you OVER THE PAST WEEK?

FATIGUE IS 0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10 FATIGUE IS A MAJOR PROBLEM

10. Over the last 6 months have you had: [Please check (✓)]

- | | |
|---|--|
| <input type="checkbox"/> No <input type="checkbox"/> Yes An operation or new illness | <input type="checkbox"/> No <input type="checkbox"/> Yes Change(s) of arthritis or other medication |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Medical emergency or stay overnight in hospital | <input type="checkbox"/> No <input type="checkbox"/> Yes Change(s) of address |
| <input type="checkbox"/> No <input type="checkbox"/> Yes A fall, broken bone, or other accident or trauma | <input type="checkbox"/> No <input type="checkbox"/> Yes Change(s) of marital status |
| <input type="checkbox"/> No <input type="checkbox"/> Yes An important new symptom or medical problem | <input type="checkbox"/> No <input type="checkbox"/> Yes Change job or work duties, quit work, retired |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Side effect(s) of any medication or drug | <input type="checkbox"/> No <input type="checkbox"/> Yes Change of medical insurance, Medicare, etc. |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Smoke cigarettes regularly | <input type="checkbox"/> No <input type="checkbox"/> Yes Change of primary care or other doctor |

Please explain any "Yes" answer below, or indicate any other health matter that affects you:

SEX: Female, Male **ETHNIC GROUP:** Asian, Black, Hispanic, White, Other _____

Your Occupation _____ **Please circle the number of years of school you have completed:**

Work Status: Full-time, Part-time, Disabled 1 2 3 4 5 6 7 8 9 10

Homemaker, Self-Employed, Retired, 11 12 13 14 15 16 17 18 19 20

Seeking work, Other _____ **Please write your weight: _____ lbs. height: _____ inches**

Your Name _____ **Date of Birth** _____ **Today's Date** _____

Page 2 of 2 Thank you for completing this questionnaire to help keep track of your medical care. R808NP2

FOR OFFICE USE ONLY: I have reviewed the questionnaire responses.

Date: _____

Signature _____