SOMS - 7

Instructions: A number of different bodily complaints are listed below. Please indicate whether you have suffered from these symptoms within the PAST 7 DAYS. Consider only symptoms for which NO CLEAR CAUSES have been found by physicians, and which have affected your well-being.

Subject ID	Month	Day	Year	Week
0 0 0 0	0 0	0 0	0 0	0 0
1 1 1 1	1 1	1 1	1 1	1 1
2 2 2 2	2 2	2 2	2 2	2 2
3 3 3 3	3 3	3 3	3 3	3 3
4 4 4 4	4 4	4 4	4 4	4 4
5 5 5 5	5 5	5 5	5 5	5 5
6 6 6 6	6 6	6 6	6 6	6 6
7 7 7 7	7 7	7 7	7 7	7 7
8 8 8 8	8 8	8 8	8 8	8 8
9 9 9 9	9 9	9 9	9 9	9 9

I have read the instructions: **Yes** ① **No** ⓪

In the PAST 7 DAYS,
I suffered from the following complaints:

Yes	No	
①	⓪	1. Headaches
①	⓪	2. Stomach pain
①	⓪	3. Back pain
①	⓪	4. Joint pain
①	⓪	5. Pain in the legs and/or arms
①	⓪	6. Chest pain
①	⓪	7. Pain in the anus
①	⓪	8. Pain during sexual intercourse
①	⓪	9. Pain during urination
①	⓪	10. Nausea
①	⓪	11. Bloating
①	⓪	12. Stomach discomfort or churning feeling in the stomach
①	⓪	13. Vomiting (pregnancy excluded)
①	⓪	14. Bringing swallowed foods up again
①	⓪	15. Hiccups, or burning sensations in chest or stomach
①	⓪	16. Food intolerance
①	⓪	17. Loss of appetite
①	⓪	18. Bad taste in mouth, or excessively coated tongue
①	⓪	19. Dry mouth
①	⓪	20. Frequent diarrhea

(OVER PLEASE)