# IBSOS COMORBID DISEASE FORM

IRRITABLE BOWEL SYNDROME STUDY



Patient Number [patid ]

Protocol Number [study ]

Date of Study Participant Visit/Contact [visitm ] [ ] [ ] mmm dd yyyy

Institution Code [instn ]

Form Week [week ] *Seq No. [seqno ] **Step No. [stepno ] Key Operator Code [keyop ]

***This area completed by Clinic Staff only.***

* Enter a '1' if this is the first of this form for this date. Designate subsequent forms on the same date with a 2, 3, etc.
** Enter the study participant's current study step number. Enter '1' if the study does not have multiple steps.

**INSRUCTIONS:**
The table below lists types of medical conditions ***a physician or other medical professional****, such as a nurse or physician's assistant,* might have treated you for or told you that you have. Please do the following for each row of the table:

1. **If a physician or other medical professional has EVER treated you for the condition listed in the row or told you that you have it:** Place an 'X' in the 'Yes' circle, then move right to the gray area to rate its severity over the past 3 months according to the directions in the *'Rate the Severity of This Medical Condition OVER THE PAST 3 MONTHS'* column.
2. **If a physician or other medical professional has NEVER treated you for the condition listed in the row or never told you that you have it:** Place an 'X' in the 'No' circle, then move down to the next row.

| **MEDICAL CONDITIONS** | | | **Rate the Severity of This Medical Condition *OVER THE PAST 3 MONTHS*** Place an 'X' over a single circle from 1-5 that best corresponds to your answer for the condition listed on the row. In making your severity rating for the condition, please consider the **overall** (1) intensity of the symptoms of the condition; (2) their frequency; and (c) their interference with your life (e.g., daily routine, job or housework, social, family activities) **over the past 3 months.** | | | | | |
|---|---|---|---|---|---|---|---|---|
| ***1. DISORDERS OF THE EYES, EARS, NOSE OR THROAT:*** | **Have you ever been treated for this condition or been told that you have it?** | | **Absent** | **Mild** | **Moderate** | **Severe** | **Very Severe** | |
| a. **Glaucoma** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb401 mb402 |
| b. **Globus** (a sensation something is stuck in your throat between meals) | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb403 mb404 |
| c. **Sleep apnea or chronic snoring** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb405 mb406 |
| d. **Insomnia** (difficulty falling asleep, difficulty staying asleep, waking up too early) | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb407 mb408 |
| e. **Nasal and/ or throat polyps** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb409 mb410 |
| f. **Hearing problems** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb411 mb412 |

CONTINUE ON NEXT PAGE

Pt. No. ☐☐☐☐☐ *Seq. No. ☐☐ **Step No. ☐☐ Date ☐☐☐ (mmm) ☐☐ (dd) ☐☐☐☐ (yyyy)

| **MEDICAL CONDITIONS** | | | **Rate the Severity of This Medical Condition *OVER THE PAST 3 MONTHS*** Place an 'X' over a single circle from 1-5 that best corresponds to your answer for the condition listed on the row. In making your severity rating for the condition, please consider the **overall** (1) intensity of the symptoms of the condition; (2) their frequency; and (c) their interference with your life (e.g., daily routine, job or housework, social, family activities) **over the past 3 months.** | | | | | |
|---|---|---|---|---|---|---|---|---|
| ***1. DISORDERS OF THE EYES, EARS, NOSE OR THROAT (continued):*** | **Have you ever been treated for this condition or been told that you have it?** | | **Absent** | **Mild** | **Moderate** | **Severe** | **Very Severe** | |
| g. **Tinnitus** (persistent ringing or other noise in the ear[s]). | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb413 mb414 |
| h. **Chronic sinusitis** (persistent inflammation of the sinuses which are hollow air spaces within the bones surrounding the nose) | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb415 mb416 |
| i. **Other disorder/ condition of the eyes, ears, nose, or throat not listed,** specify (if nothing, leave the specify line blank, check 'No,' and skip to the next section): mb419 _____ | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb417 mb418 |

| ***2. SKIN OR DERMATOLOGICAL DISORDERS:*** | **Have you ever been treated for this condition or been told that you have it?** | | **Absent** | **Mild** | **Moderate** | **Severe** | **Very Severe** | |
|---|---|---|---|---|---|---|---|---|
| a. **Acne** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb420 mb421 |
| b. **Recurrent skin rash** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb422 mb423 |
| c. **Cold sore on or near lips** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb424 mb425 |
| d. **Canker sores in mouth** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb426 mb427 |

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Pt. No. ☐☐☐☐☐ *Seq. No. ☐☐ **Step No. ☐☐ Date ☐☐☐ ☐☐ ☐☐☐☐ mmm dd yyyy

| **MEDICAL CONDITIONS** | | | **Rate the Severity of This Medical Condition *OVER THE PAST 3 MONTHS*** Place an 'X' over a single circle from 1-5 that best corresponds to your answer for the condition listed on the row. In making your severity rating for the condition, please consider the **overall** (1) intensity of the symptoms of the condition; (2) their frequency; and (c) their interference with your life (e.g., daily routine, job or housework, social, family activities) **over the past 3 months.** | | | | | |
|---|---|---|---|---|---|---|---|---|
| ***2. SKIN OR DERMATOLOGICAL DISORDERS (continued):*** | **Have you ever been treated for this condition or been told that you have it?** | | **Absent** | **Mild** | **Moderate** | **Severe** | **Very Severe** | |
| e. **Shingles** (herpes zoster, an outbreak of rashes or blisters caused by the same virus that causes chickenpox) | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb428 mb429 |
| f. **Post herpetic neuralgia** (sharp, burning, pain that occurs after the shingles rash/blisters disappear) | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb430 mb431 |
| g. **Psoriasis** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb432 mb433 |
| h. **Eczema** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb434 mb435 |
| i. **Severe burns** resulting in disfiguration or lack of sensation in the affected area | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb436 mb437 |
| j. **Other skin or dermatological disorder not listed**, specify (if nothing, leave the specify line blank, check 'No,' and skip to the next section): mb440 _____ | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb438 mb439 |

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Pt. No. ☐☐☐☐☐ *Seq. No. ☐☐ **Step No. ☐☐ Date ☐☐☐ (mmm) ☐☐ (dd) ☐☐☐☐ (yyyy)

| **MEDICAL CONDITIONS** | | | **Rate the Severity of This Medical Condition *OVER THE PAST 3 MONTHS*** Place an 'X' over a single circle from 1-5 that best corresponds to your answer for the condition listed on the row. In making your severity rating for the condition, please consider the **overall** (1) intensity of the symptoms of the condition; (2) their frequency; and (c) their interference with your life (e.g., daily routine, job or housework, social, family activities) **over the past 3 months.** | | | | | |
|---|---|---|---|---|---|---|---|---|
| ***3. ORAL DISEASES*** | **Have you ever been treated for this condition or been told that you have it?** | | **Absent** | **Mild** | **Moderate** | **Severe** | **Very Severe** | |
| a. **Gingivitis** (inflammation of the gums) | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb441 mb442 |
| b. **Thrush** (oral candidiasis) | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb443 mb444 |
| c. **Bruxism** (repeated grinding of teeth) | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb445 mb446 |
| d **Other oral disease not listed,** specify (if nothing, leave the specify line blank, check 'No,' and skip to the next section): mb449 _____ | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb447 mb448 |

| ***4. BRAIN, NEUROLOGICAL, OR NERVOUS SYSTEM DISORDERS:*** | **Have you ever been treated for this condition or been told that you have it?** | | **Absent** | **Mild** | **Moderate** | **Severe** | **Very Severe** | |
|---|---|---|---|---|---|---|---|---|
| a. **Tension headache** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb450 mb451 |
| b. **Migraine headache** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb452 mb453 |
| c. **Epilepsy or other seizure disorder** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb454 mb455 |
| d. **Multiple sclerosis** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb456 mb457 |
| e. **Learning disability** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb458 mb459 |
| f. **Autism or Aspergers Syndrome** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb460 mb461 |
| g. **Spinal cord injury** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb462 mb463 |
| h. **Other brain, neurological or nervous system disorder not listed,** specify (if nothing, leave the specify line blank, check 'No,' and skip to the next section): mb466 _____ | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb464 mb465 |

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Pt. No. ☐☐☐☐☐ *Seq. No. ☐☐ **Step No. ☐☐ Date ☐☐☐ ☐☐ ☐☐☐☐ mmm dd yyyy

| **MEDICAL CONDITIONS** | | | **Rate the Severity of This Medical Condition *OVER THE PAST 3 MONTHS*** Place an 'X' over a single circle from 1-5 that best corresponds to your answer for the condition listed on the row. In making your severity rating for the condition, please consider the **overall** (1) intensity of the symptoms of the condition; (2) their frequency; and (c) their interference with your life (e.g., daily routine, job or housework, social, family activities) **over the past 3 months.** | | | | | |
|---|---|---|---|---|---|---|---|---|
| **5 *HEART OR CARDIOVASCULAR DISORDERS:*** | **Have you ever been treated for this condition or been told that you have it?** | | **Absent** | **Mild** | **Moderate** | **Severe** | **Very Severe** | |
| a. **Heart murmur or mitral valve prolapse** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb467 mb468 |
| b. **Coronary artery disease (angina or myocardial infarction [heart attack]).** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb469 mb470 |
| c. **Tachycardia, Bradycardia or other heart arrhythmia** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb471 mb472 |
| d. **Congestive heart failure** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb473 mb474 |
| e. **Chest pain *NOT due to cardiovascular disease*** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb475 mb476 |
| f. **Other heart or cardiovascular disorder not listed,** specify (if nothing, leave the specify line blank, check 'No,' and skip to the next section): mb479 _____ | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb477 mb478 |

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Pt. No. ☐☐☐☐☐ *Seq. No. ☐☐ **Step No. ☐☐ Date ☐☐☐ ☐☐ ☐☐☐☐ mmm dd yyyy

| **MEDICAL CONDITIONS** | | | **Rate the Severity of This Medical Condition *OVER THE PAST 3 MONTHS*** Place an 'X' over a single circle from 1-5 that best corresponds to your answer for the condition listed on the row. In making your severity rating for the condition, please consider the **overall** (1) intensity of the symptoms of the condition; (2) their frequency; and (c) their interference with your life (e.g., daily routine, job or housework, social, family activities) **over the past 3 months.** | | | | | |
|---|---|---|---|---|---|---|---|---|
| ***6. CIRCULATORY SYSTEM DISORDERS:*** | **Have you ever been treated for this condition or been told that you have it?** | | **Absent** | **Mild** | **Moderate** | **Severe** | **Very Severe** | |
| a. **Anemia** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb480 mb481 |
| b. **Peripheral vascular disease** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb482 mb483 |
| c. **High blood pressure or hypertension** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb484 mb485 |
| d. **Low blood pressure** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb486 mb487 |
| e. **High blood cholesterol, or triglyceride levels or hyperlipidemia** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb488 mb489 |
| f. **Orthostatic hypotension or postural hypotension** (i.e., dizziness or feeling faint and a sudden fall in blood pressure when moving from a sitting or reclining position to a standing position) | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb490 mb491 |
| g. **Stroke or transient ischemic attack** (TIA) | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb492 mb493 |
| h. **Other circulatory system disorder not listed,** specify (if nothing, leave the specify line blank, check 'No,' and skip to the next section): mb496 _____ | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb494 mb495 |

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Pt. No. ☐☐☐☐☐ *Seq. No. ☐☐ **Step No. ☐☐ Date ☐☐☐ ☐☐ ☐☐☐☐ mmm dd yyyy

| **MEDICAL CONDITIONS** | | | **Rate the Severity of This Medical Condition *OVER THE PAST 3 MONTHS*** Place an 'X' over a single circle from 1-5 that best corresponds to your answer for the condition listed on the row. In making your severity rating for the condition, please consider the **overall** (1) intensity of the symptoms of the condition; (2) their frequency; and (c) their interference with your life (e.g., daily routine, job or housework, social, family activities) **over the past 3 months.** | | | | | |
|---|---|---|---|---|---|---|---|---|
| **7. *RESPIRATORY OR LUNG DISORDERS:*** | **Have you ever been treated for this condition or been told that you have it?** | | **Absent** | **Mild** | **Moderate** | **Severe** | **Very Severe** | |
| a. **Seasonal allergies** (to grasses or trees, or hay fever) | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb497 mb498 |
| b. **Asthma** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb499 mb500 |
| c. **Chronic obstructive pulmonary disease** (chronic bronchitis or emphysema) | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb501 mb502 |
| d. **Interstitial lung disease** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb503 mb504 |
| e. **Other respiratory or lung disorder not listed,** specify (if nothing, leave the specify line blank, check 'No,' and skip to the next section): mb507 _____ | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb505 mb506 |

| **8. *ENDOCRINE SYSTEM DISORDERS:*** | **Have you ever been treated for this condition or been told that you have it?** | | **Absent** | **Mild** | **Moderate** | **Severe** | **Very Severe** | |
|---|---|---|---|---|---|---|---|---|
| a. **Diabetes or elevated blood sugar** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb508 mb509 |
| b. **Hyperthyroid disorder** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb510 mb511 |
| c. **Hypothyroid disorder** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb512 mb513 |
| d. **Low blood sugar** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb514 mb515 |
| e. **Other endocrine system disorder not listed,** specify (if nothing, leave the specify line blank, check 'No,' and skip to the next section): mb518 _____ | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb516 mb517 |

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Pt. No. ☐☐☐☐☐ *Seq. No. ☐☐ **Step No. ☐☐ Date ☐☐☐ ☐☐ ☐☐☐☐ mmm dd yyyy

| **MEDICAL CONDITIONS** | **Have you ever been treated for this condition or been told that you have it?** | | **Rate the Severity of This Medical Condition *OVER THE PAST 3 MONTHS*** Place an 'X' over a single circle from 1-5 that best corresponds to your answer for the condition listed on the row. In making your severity rating for the condition, please consider the **overall** (1) intensity of the symptoms of the condition; (2) their frequency; and (c) their interference with your life (e.g., daily routine, job or housework, social, family activities) **over the past 3 months.** | | | | | |
|---|---|---|---|---|---|---|---|---|
| ***9. KIDNEY OR GENITOURINARY DISORDERS:*** | | | **Absent** | **Mild** | **Moderate** | **Severe** | **Very Severe** | |
| a. **Kidney stones** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb519 mb520 |
| b. **Recurrent urinary tract infections**(more than 2 per year) | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb521 mb522 |
| c. **Kidney failure or kidney removal** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb523 mb524 |
| d. **Chronic nephritis** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb525 mb526 |
| e. **Interstitial cystitis or painful bladder syndrome** (Irritable Bladder Syndrome) | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb527 mb528 |
| f. **Chronic pelvic pain** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb529 mb530 |
| g. **Sexually transmitted diseases** such as genital human papillomavirus (HPV) infection,genital herpes, chlamydia, syphilis, gonorrhea, HIV, or AIDS | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb531 mb532 |
| h. **Low sexual desire** *(both men and women)* | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb533 mb534 |
| i. **Infertility** *(both men and women)* | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb535 mb536 |
| j. **Discharge from urethra or penis** *(both men and women)* | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb537 mb538 |
| **INSTRUCTIONS FOR *WOMEN* ONLY AT THIS POINT: SKIP TO QUESTION 9l AND CONTINUE (LEAVE QUESTION 9k BLANK)** | | | | | | | | |
| k. **Prostate disease such as enlarged prostate gland (BPH) or prostatitis** *(men only)* | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb539 mb540 |

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Pt. No. ☐☐☐☐☐ *Seq. No. ☐☐ **Step No. ☐☐ Date ☐☐☐ ☐☐ ☐☐☐☐ mmm dd yyyy

| **MEDICAL CONDITIONS** | | | **Rate the Severity of This Medical Condition *OVER THE PAST 3 MONTHS*** Place an 'X' over a single circle from 1-5 that best corresponds to your answer for the condition listed on the row. In making your severity rating for the condition, please consider the **overall** (1) intensity of the symptoms of the condition; (2) their frequency; and (c) their interference with your life (e.g., daily routine, job or housework, social, family activities) **over the past 3 months.** | | | | | |
|---|---|---|---|---|---|---|---|---|
| ***9. KIDNEY OR GENITOURINARY DISORDERS (continued):*** | **Have you ever been treated for this condition or been told that you have it?** | | **Absent** | **Mild** | **Moderate** | **Severe** | **Very Severe** | |
| **INSTRUCTIONS FOR *MEN* ONLY AT THIS POINT: SKIP TO QUESTION 9r AND CONTINUE (LEAVE QUESTIONS 9l-9q BLANK)** | | | | | | | | |
| l. **Endometriosis** *(women only)* | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb541 mb542 |
| m. **Ovarian cysts** *(women only)* | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb543 mb544 |
| n. **Uterine fibroids** *(women only)* | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb545 mb546 |
| o. **Dyspareunia or pain during sexual intercourse** *(women only)* | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb547 mb548 |
| p. **Abnormal PAP smear results or cervical dysplasia** *(women only)* | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb549 mb550 |
| q. **Menstrual disorders such as premenstrual dysphoric syndrome** (PMD, premenstrual syndrome) *(women only)* | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb551 mb552 |
| r. **Other kidney or genitourinary system disorder not listed,** specify (if nothing, leave the specify line blank, check 'No,' and skip to the next section): mb555 _____ | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb553 mb554 |

CONTINUE ON NEXT PAGE

**IBSOS COMORBID DISEASE FORM** 

Pt. No. ☐☐☐☐☐ *Seq. No. ☐☐ **Step No. ☐☐ Date ☐☐☐ ☐☐ ☐☐☐☐ mmm dd yyyy

| **MEDICAL CONDITIONS** | **Have you ever been treated for this condition or been told that you have it?** | | **Rate the Severity of This Medical Condition *OVER THE PAST 3 MONTHS*** Place an 'X' over a single circle from 1-5 that best corresponds to your answer for the condition listed on the row. In making your severity rating for the condition, please consider the **overall** (1) intensity of the symptoms of the condition; (2) their frequency; and (c) their interference with your life (e.g., daily routine, job or housework, social, family activities) **over the past 3 months.** | | | | | |
|---|---|---|---|---|---|---|---|---|
| ***10. DIGESTIVE SYSTEM DISORDERS:*** | | | **Absent** | **Mild** | **Moderate** | **Severe** | **Very Severe** | |
| a. **Gastroesophageal reflux disease (GERD) or unexplained heartburn** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb556 mb557 |
| b. **Dyspepsia or functional dyspepsia** (unexplained indigestion) | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb558 mb559 |
| c. **Dysphagia** (difficulty swallowing solids and/or liquids or food sticking in the esophagus) | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb560 mb561 |
| d. **Odynophagia** (painful swallowing) | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb562 mb563 |
| e. **Unexplained vomiting** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb564 mb565 |
| f. **Unexplained frequent belching** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb566 mb567 |
| g. **Chronic proctalgia** (recurrent episodes of pain in the anal region) | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb568 mb569 |
| h. **Recurrent acute pancreatitis** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb570 mb571 |
| i. **Chronic pancreatitis** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb572 mb573 |
| j. **Pancreatic cysts** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb574 mb575 |
| k. **Peptic Ulcer Disease** (ulcer of the stomach and small intestine) | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb576 mb577 |
| l. **Gallbladder disease or gallstones** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb578 mb579 |
| m. **Hepatitis** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb580 mb581 |
| n. **Cirrhosis of the liver** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb582 mb583 |
| o. **Diverticulitis** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb584 mb585 |
| p. **Diverticulosis** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb586 mb587 |
| q. **Other digestive system disorder not listed,** specify (if nothing, leave the specify line blank, check 'No,' and skip to the next section): | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb588 mb589 |

mb590 _____'AGE

Pt. No. ☐☐☐☐☐ *Seq. No. ☐☐ **Step No. ☐☐ Date ☐☐☐ (mmm) ☐☐ (dd) ☐☐☐☐ (yyyy)

| **MEDICAL CONDITIONS** | | | **Rate the Severity of This Medical Condition *OVER THE PAST 3 MONTHS*** Place an 'X' over a single circle from 1-5 that best corresponds to your answer for the condition listed on the row. In making your severity rating for the condition, please consider the **overall** (1) intensity of the symptoms of the condition; (2) their frequency; and (c) their interference with your life (e.g., daily routine, job or housework, social, family activities) **over the past 3 months.** | | | | | |
|---|---|---|---|---|---|---|---|---|
| ***11. MUSCULOSKELETAL DISORDERS:*** | **Have you ever been treated for this condition or been told that you have it?** | | **Absent** | **Mild** | **Moderate** | **Severe** | **Very Severe** | |
| a. **Rheumatoid arthritis** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb591 mb592 |
| b. **Osteoarthritis** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb593 mb594 |
| c. **Ankylosing spondylitis** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb595 mb596 |
| d. **Cervical spondylitis** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb597 mb598 |
| e. **Gout** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb599 mb600 |
| f. **Chronic osteomyelitis** (infection of the bone) | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb601 mb602 |
| g. **Osteoporosis** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb603 mb604 |
| h. **Fibromyalgia** (widespread pain) | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb605 mb606 |
| i. **Cervical strain** (or whiplash) | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb607 mb608 |
| j. **Chronic low back pain** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb609 mb610 |
| k. **Bulging or herniated disc** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb611 mb612 |
| l. **Spinal stenosis** (cervical or lumbar spine) | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb613 mb614 |
| m. **Degenerative joint disease** (e.g., spine) | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb615 mb616 |
| n. **Chronic tendinitis** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb617 mb618 |
| o. **Chronic bursitis** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb619 mb620 |
| p. **Systemic Lupus Erythematosus** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb621 mb622 |
| q. **Temporomandibular joint disorder** (TMD or TMJ) | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb623 mb624 |

CONTINUE ON NEXT PAGE

Pt. No. ☐☐☐☐☐ *Seq. No. ☐☐ **Step No. ☐☐ Date ☐☐☐ ☐☐ ☐☐☐☐ mmm dd yyyy

| **MEDICAL CONDITIONS** | | | **Rate the Severity of This Medical Condition *OVER THE PAST 3 MONTHS*** Place an 'X' over a single circle from 1-5 that best corresponds to your answer for the condition listed on the row. In making your severity rating for the condition, please consider the **overall** (1) intensity of the symptoms of the condition; (2) their frequency; and (c) their interference with your life (e.g., daily routine, job or housework, social, family activities) **over the past 3 months.** | | | | | |
|---|---|---|---|---|---|---|---|---|
| ***11. MUSCULOSKELETAL DISORDERS (continued):*** | **Have you ever been treated for this condition or been told that you have it?** | | **Absent** | **Mild** | **Moderate** | **Severe** | **Very Severe** | |
| r. **Scleroderma** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb625 mb626 |
| s. **Chronic fatigue syndrome** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb627 mb628 |
| t. **Other musculoskeletal disorder not listed,** specify (if nothing, leave the specify line blank, check 'No,' and skip to the next section): mb631 _____ | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb629 mb630 |

| ***12. CANCER:*** | **Have you ever been treated for this condition or been told that you have it?** | | **Absent** | **Mild** | **Moderate** | **Severe** | **Very Severe** | |
|---|---|---|---|---|---|---|---|---|
| a. **Skin cancer or melanoma** | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb632 mb633 |
| b. **Any cancer other than skin cancer or melanoma,** specify (if nothing, leave the specify line blank and check 'No': mb636 _____ | 2-No | 1-Yes → | 1 | 2 | 3 | 4 | 5 | mb634 mb635 |



Date Form Keyed (DO NOT KEY): _____ / _____ / _____