Participant ID: _____ Participant Initials: _____

Clinical Center: _____ Site: _____ Visit Number: _____ Reset Patient / RC

CRF Date: ____ / ____ / ____ RC ID: _____ Reset All

SYMPTOMS LIST

Thinking back on the ***last month***, mark the number of days in which you have felt each of the symptoms listed below. If you never felt the symptom, then enter a zero in the space. ***Do not leave it blank***. Next, put a ***check*** under the column indicating the severity of each of the symptoms that was felt. Leave severity blank if symptom not felt.

Symptoms	Number of Days in Past Month *(Enter 0 if None)*	Severity		
		Mild Symptoms did not interfere with usual activities	**Moderate** Symptoms interfered somewhat with usual activities	**Severe** Symptoms were so bothersome that usual activities could not be performed
1. A bad taste in your mouth?	___ ___	❑1	❑2	❑3
2. Loss of appetite?	___ ___	❑1	❑2	❑3
3. Nausea or being sick to your stomach?	___ ___	❑1	❑2	❑3
4. Vomiting?	___ ___	❑1	❑2	❑3
5. Heartburn?	___ ___	❑1	❑2	❑3
6. Abdominal bloating or gas?	___ ___	❑1	❑2	❑3
7. Diarrhea?	___ ___	❑1	❑2	❑3
8. Constipation?	___ ___	❑1	❑2	❑3
9. Hiccoughs?	___ ___	❑1	❑2	❑3
10. Itching?	___ ___	❑1	❑2	❑3
11. Hives or another type of rash?	___ ___	❑1	❑2	❑3
12. Easy bruising or bleeding?	___ ___	❑1	❑2	❑3
13. Lack of pep and energy?	___ ___	❑1	❑2	❑3
14. Tiring easily, weakness?	___ ___	❑1	❑2	❑3
15. Muscle cramps?	___ ___	❑1	❑2	❑3
16. Numbness and tingling in your hands and feet?	___ ___	❑1	❑2	❑3
17. Feeling faint when you stand up?	___ ___	❑1	❑2	❑3
18. Difficulty in falling or staying asleep?	___ ___	❑1	❑2	❑3
19. Falling asleep during the day?	___ ___	❑1	❑2	❑3
20. Feeling irritable?	___ ___	❑1	❑2	❑3
21. Decreased alertness?	___ ___	❑1	❑2	❑3
22. Forgetfulness?	___ ___	❑1	❑2	❑3
23. Blurred vision?	___ ___	❑1	❑2	❑3
24. Other unexpected symptoms? ***Specify:*** _____	___ ___	❑1	❑2	❑3

For Research Coordinator use only: CRF was: ❑1 Self-administered ❑2 Interviewer-administered