Participant ID: **Participant Initials:**

Clinical Center: **Site:** **Visit Number:**

CRF Date: **RC ID:**

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. For the "Number of Days in Past Month, if less than 10 days, use leading zeros (e.g. 5 days = 05).

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