



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.

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?	__ __	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
2. Loss of appetite?	__ __	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
3. Nausea or being sick to your stomach?	__ __	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
4. Vomiting?	__ __	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
5. Heartburn?	__ __	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
6. Abdominal bloating or gas?	__ __	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
7. Diarrhea?	__ __	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
8. Constipation?	__ __	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
9. Hiccoughs?	__ __	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
10. Itching?	__ __	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
11. Hives or another type of rash?	__ __	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
12. Easy bruising or bleeding?	__ __	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
13. Lack of pep and energy?	__ __	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
14. Tiring easily, weakness?	__ __	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
15. Muscle cramps?	__ __	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
16. Numbness and tingling in your hands and feet?	__ __	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
17. Feeling faint when you stand up?	__ __	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
18. Difficulty in falling or staying asleep?	__ __	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
19. Falling asleep during the day?	__ __	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
20. Feeling irritable?	__ __	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
21. Decreased alertness?	__ __	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
22. Forgetfulness?	__ __	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
23. Blurred vision?	__ __	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
24. Other unexpected symptoms? <i>Specify:</i>	__ __	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃

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