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

CONTINUE ON NEXT PAGE

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

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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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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

CONTINUE ON NEXT PAGE

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

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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

CONTINUE ON NEXT PAGE

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

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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

CONTINUE ON NEXT PAGE

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

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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

CONTINUE ON NEXT PAGE

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

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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

CONTINUE ON NEXT PAGE

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

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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

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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

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

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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

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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): _____ / _____ / _____