MAPP research network MAPP II SPS	**Participant ID:** __ __ __ __ __ __	**Pin #** __ __ __ __
	Discovery Site: __ __	**Clinical Center** __ __
	CRF Date: __ __/__ __/__ __ __ __	**Visit #:** __ __

COMPLEX MEDICAL SYMPTOMS INVENTORY

Participant completes via online survey at the Screening Week 0 contact.

Instructions: *Please read the following list of symptoms. If you have had any of these symptoms for **at least three (3) months in the past year**, please mark the box.*

Q#	SYMPTOM	3 months during the last year (12 months) (A)	*For staff use only*
1	Muscle or joint pain	❑$_1$ Yes ❑$_0$ No	❑$_1$M:FM ❑$_1$M:CFS
2	Morning stiffness	❑$_1$ Yes ❑$_0$ No	
3	Muscle spasms	❑$_1$ Yes ❑$_0$ No	
4	Persistent fatigue not relieved with rest	❑$_1$ Yes ❑$_0$ No	❑$_1$M:CFS
5	Extreme fatigue following exercise or mild exertion	❑$_1$ Yes ❑$_0$ No	
6	Recurrent fevers	❑$_1$ Yes ❑$_0$ No	
7	Dry eyes	❑$_1$ Yes ❑$_0$ No	
8	Dry mouth	❑$_1$ Yes ❑$_0$ No	
9	Fingers turn blue and/or white in the cold	❑$_1$ Yes ❑$_0$ No	
10	Numbness or tingling in arms or legs	❑$_1$ Yes ❑$_0$ No	
11	Shortness of breath during normal activity	❑$_1$ Yes ❑$_0$ No	
12	Impaired memory, concentration or attention	❑$_1$ Yes ❑$_0$ No	
13	Chest pain	❑$_1$ Yes ❑$_0$ No	
14	Palpitations	❑$_1$ Yes ❑$_0$ No	
15	Rapid heart rate	❑$_1$ Yes ❑$_0$ No	
16	Heartburn	❑$_1$ Yes ❑$_0$ No	
17	Vomiting	❑$_1$ Yes ❑$_0$ No	
18	Nausea	❑$_1$ Yes ❑$_0$ No	
19	Abdominal pain or discomfort	❑$_1$ Yes ❑$_0$ No	❑$_1$M:IBS
20	Problems with balance	❑$_1$ Yes ❑$_0$ No	
21	Dizziness	❑$_1$ Yes ❑$_0$ No	
22	Ringing in ears	❑$_1$ Yes ❑$_0$ No	
23	Ear pain	❑$_1$ Yes ❑$_0$ No	❑$_1$M:TMJ
24	Sensation of ear blockage or fullness	❑$_1$ Yes ❑$_0$ No	

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COMPLEX MEDICAL SYMPTOMS INVENTORY

Participant completes via online survey at the Screening Week 0 contact.

Q#	SYMPTOM	3 months during the last year (12 months) (A)	*For staff use only*
25	Sinus pressure	❑$_1$ Yes ❑$_0$ No	
26	Pelvic/bladder discomfort (pain or pressure)	❑$_1$ Yes ❑$_0$ No	
27	Urinary urgency	❑$_1$ Yes ❑$_0$ No	
28	Urinary frequency, >8/day during waking hours	❑$_1$ Yes ❑$_0$ No	
29	Frequent nocturia (nighttime urination), 3/night	❑$_1$ Yes ❑$_0$ No	
30	Sensation of bladder fullness after urination	❑$_1$ Yes ❑$_0$ No	
31	Jaw and/or face pain	❑$_1$ Yes ❑$_0$ No	❑$_1$M:TMJ
32	Temple pain	❑$_1$ Yes ❑$_0$ No	
33	Pulsating and/or one-sided headache pain or migraines	❑$_1$ Yes ❑$_0$ No	❑$_1$M:MI
34	Pressing/tightening headache pain or tension headaches	❑$_1$ Yes ❑$_0$ No	
35	Sensitivity to certain chemicals, such as perfumes, laundry detergents, gasoline and others	❑$_1$ Yes ❑$_0$ No	
36	Sensitivity to sound	❑$_1$ Yes ❑$_0$ No	
37	Sensitivity to odors	❑$_1$ Yes ❑$_0$ No	
38	Body feeling tender	❑$_1$ Yes ❑$_0$ No	
39	Frequent sensitivity to bright lights	❑$_1$ Yes ❑$_0$ No	
FEMALES ONLY:			
40	Constant burning or raw feeling at the opening of vagina	❑$_1$ Yes ❑$_0$ No	❑$_1$M:VDYN
41	Itching at opening of vagina	❑$_1$ Yes ❑$_0$ No	