
	Participant ID: _____	Pin # _____
	Discovery Site: _____	Clinical Center _____
	CRF Date: ____/____/____	Visit #: _____

COMPLEX MEDICAL SYMPTOMS INVENTORY

Participant completes this form at the Six-month and Twelve-month contacts.

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 appropriate box.

Q#	SYMPTOM	3 months during the last year (12 months) (A)	For staff use only
1	Muscle or joint pain	<input type="checkbox"/> ₁	<input type="checkbox"/> ₁ M:FM <input type="checkbox"/> ₁ M:CFS
2	Morning stiffness	<input type="checkbox"/> ₁	
3	Muscle spasms	<input type="checkbox"/> ₁	
4	Persistent fatigue not relieved with rest	<input type="checkbox"/> ₁	<input type="checkbox"/> ₁ M:CFS
5	Extreme fatigue following exercise or mild exertion	<input type="checkbox"/> ₁	
6	Recurrent fevers	<input type="checkbox"/> ₁	
7	Dry eyes	<input type="checkbox"/> ₁	
8	Dry mouth	<input type="checkbox"/> ₁	
9	Fingers turn blue and/or white in the cold	<input type="checkbox"/> ₁	
10	Numbness or tingling in arms or legs	<input type="checkbox"/> ₁	
11	Shortness of breath during normal activity	<input type="checkbox"/> ₁	
12	Impaired memory, concentration or attention	<input type="checkbox"/> ₁	
13	Chest pain	<input type="checkbox"/> ₁	
14	Palpitations	<input type="checkbox"/> ₁	
15	Rapid heart rate	<input type="checkbox"/> ₁	
16	Heartburn	<input type="checkbox"/> ₁	
17	Vomiting	<input type="checkbox"/> ₁	
18	Nausea	<input type="checkbox"/> ₁	
19	Abdominal pain or discomfort	<input type="checkbox"/> ₁	<input type="checkbox"/> ₁ M:IBS
20	Problems with balance	<input type="checkbox"/> ₁	
21	Dizziness	<input type="checkbox"/> ₁	
22	ringing in ears	<input type="checkbox"/> ₁	
23	Ear pain	<input type="checkbox"/> ₁	<input type="checkbox"/> ₁ M:TMJ

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Q#	SYMPTOM	3 months during the last year (12 months) (A)	For staff use only
24	Sensation of ear blockage or fullness	<input type="checkbox"/> ₁	
25	Sinus pressure	<input type="checkbox"/> ₁	
26	Pelvic/bladder discomfort (pain or pressure)	<input type="checkbox"/> ₁	
27	Urinary urgency	<input type="checkbox"/> ₁	
28	Urinary frequency, >8/day during waking hours	<input type="checkbox"/> ₁	
29	Frequent nocturia (nighttime urination), 3/night	<input type="checkbox"/> ₁	
30	Sensation of bladder fullness after urination	<input type="checkbox"/> ₁	
31	Jaw and/or face pain	<input type="checkbox"/> ₁	<input type="checkbox"/> ₁ M:TMJ
32	Temple pain	<input type="checkbox"/> ₁	
33	Pulsating and/or one-sided headache pain or migraines	<input type="checkbox"/> ₁	<input type="checkbox"/> ₁ M:MI
34	Pressing/tightening headache pain or tension headaches	<input type="checkbox"/> ₁	
35	Sensitivity to certain chemicals, such as perfumes, laundry detergents, gasoline and others	<input type="checkbox"/> ₁	
36	Sensitivity to sound	<input type="checkbox"/> ₁	
37	Sensitivity to odors	<input type="checkbox"/> ₁	
38	Body feeling tender	<input type="checkbox"/> ₁	
39	Frequent sensitivity to bright lights	<input type="checkbox"/> ₁	
FEMALES ONLY:			
40	Constant burning or raw feeling at the opening of vagina	<input type="checkbox"/> ₁	
41	Itching at opening of vagina	<input type="checkbox"/> ₁	