



Participant ID: _____

Pin # _____

Discovery Site: _____

Clinical Center _____

CRF Date: ___/___/_____

Visit #: _____

COMPLEX MEDICAL SYMPTOMS INVENTORY

Current Chronic Fatigue Symptoms (Fukuda 1994 criteria)

RESEARCH COORDINATOR ADMINISTERS TO PATIENT AT BASELINE CONTACT, IF NEEDED.

Instructions: The following questions are related to periods of fatigue lasting at least 6 months. An episode of fatigue or exhaustion is defined as "beginning" when you no longer felt that you had your normal amount of energy. An episode of fatigue or exhaustion is defined as "ending" when you felt basically back to normal.

1. Have you ever had a period of ongoing fatigue or exhaustion lasting at least 6 months? ₁ Yes ₀ No **(Stop)**
2. Do you consider your fatigue lifelong [from birth]? ₁ Yes ₀ No
3. Are you currently experiencing such a period of ongoing fatigue or exhaustion lasting at least 6 months? ₁ Yes ₀ No
4. During the last 6 months, have you experienced ongoing fatigue or exhaustion? ₁ Yes ₀ No **(Stop)**
5. When did this period of fatigue begin? YEAR _____ MONTH _____
6. Are you currently still experiencing this period of fatigue? ₁ Yes ₀ No **(Stop)**
7. Compared to before the fatigue began, in the last 6 months have you substantially reduced your work or educational activities because of your fatigue? ₁ Yes ₀ No
8. Compared to before the fatigue began, in the last 6 months have you substantially reduced your personal or social activities because of your fatigue? ₁ Yes ₀ No
9. Is your fatigue present only following exertion, strenuous work, or exercise? That is, do you have fatigue at no other time except following exertion, strenuous work, or exercise? ₁ Yes ₀ No
10. Is your fatigue substantially relieved by rest? ₁ Yes ₀ No
11. After you rest, do you feel back to normal, that is, back to how you felt before the period of fatigue began? ₁ Yes ₀ No
12. In the last 6 months, have you experienced **impairment of short-term memory or concentration**? ₁ Yes ₀ No
 - a. If **Yes**, have these **memory or concentration problems** been severe enough to cause you to substantially reduce your occupational, educational, social or personal activities? ₁ Yes ₀ No
 - b. If **Yes**, have you had **memory or concentration problems** either persistently or recurrently (either continuously or off and on) over the entire last 6 months? ₁ Yes ₀ No



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13. In the last 6 months, have you experienced a **sore throat**? ₁ Yes ₀ No
- a. If **Yes**, have you had a **sore throat** either persistently or recurrently (either continuously or off and on) over the entire last 6 months? ₁ Yes ₀ No
14. In the last 6 months, have you experienced **muscle pain**? ₁ Yes ₀ No
- a. Have you had **muscle pain** either persistently or recurrently (either continuously or off and on) over the entire last 6 months? ₁ Yes ₀ No
15. In the last 6 months, have you experienced **joint pain involving more than one joint WITHOUT swelling or redness**? ₁ Yes ₀ No
- a. Have you had this **joint pain** either persistently or recurrently (either continuously or off and on) over the entire last 6 months? ₁ Yes ₀ No
16. In the last 6 months, have you experienced **headaches of a new type, pattern or severity**? ₁ Yes ₀ No
- a. Have you had this **new type of headache** either persistently or recurrently (either continuously or off and on) over the entire last 6 months? ₁ Yes ₀ No
17. In the last 6 months, have you experienced **non-refreshing sleep or not feeling rested when you wake up**? ₁ Yes ₀ No
- a. Have you had **non-refreshing sleep or not feeling rested when you wake up** either persistently or recurrently (either continuously or off and on) over the entire last 6 months? ₁ Yes ₀ No
18. In the last 6 months, have you experienced **fatigue or exhaustion**, after exertion, lasting more than 24 hours that you did not experience before the fatigue began? ₁ Yes ₀ No
- a. Have you had this **new type of fatigue or exhaustion** either persistently or recurrently (either continuously or off and on) over the entire last 6 months? ₁ Yes ₀ No
19. In the last 6 months, have you experienced **tender lymph glands in your neck or armpits**? ₁ Yes ₀ No
- a. Have you had **tender lymph glands** in your neck or armpits either persistently or recurrently (either continuously or off and on) over the entire last 6 months? ₁ Yes ₀ No

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CFS diagnostic criteria

CF = Major fatigue criteria + 4 or more ancillary criteria

- **MAJOR FATIGUE CRITERIA [YES/NO] are met if:**

Q#7 = yes OR Q8 = yes	(activity is reduced)	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No
Q#9 = no	(fatigue not present ONLY after exertion)	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No
Q#10 = no OR Q#11 = no	(fatigue not relieved by rest)	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No
Q.#2 = no	(fatigue not lifelong)	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No

- **ANCILLARY SYMPTOMS CRITERIA [YES/NO]:**

4 or more of :

Q#12a = yes AND Q#12b = yes	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No
Q#13a = yes	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No
Q#14a = yes	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No
Q#15a = yes	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No
Q#16a = yes	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No
Q#17a = yes	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No
Q#18a = yes	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No
Q#19a = yes	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No