Study #021 Plate #350 Seq #005

Participant ID # ☐☐ – ☐☐☐☐ – ☐☐ **Today's Date** ☐☐ ☐☐ ☐☐ (day month year)

MEDICAL HISTORY

Follow-up Medical History Questionnaire

Since your last SICCA study visit, have you received a new diagnosis (made by a physician) of any of the following (if you do not recognize the name of any of the following conditions, you most likely have never been diagnosed with it):

Questions 3-17: Use derived variable "other_ai_f". Where Yes = self-reported at least one autoimmune disease on follow-up.

		yes	no
fm1	1. Type 1 Diabetes (Insulin dependent)	1	2
fm2	2. Type 2 Diabetes (Non-insulin dependent)	1	2
fm3	3. Multiple Sclerosis	1	2
fm4	4. Behçet's Disease	1	2
fm5	5. Psoriasis	1	2
fm6	6. Myasthenia Gravis	1	2
fm7	7. Vitiligo	1	2
fm8	8. Pemphigus Vulgaris	1	2
fm9	9. Ulcerative Colitis	1	2
fm10	10. Crohn's Disease	1	2
fm11	11. Wegener's Granulomatosis	1	2
fm12	12. Discoid Lupus	1	2
fm13	13. Ankylosing Spondylitis	1	2
fm14	14. Pernicious or Hemolytic Anemia	1	2
fm15	15. Graves' Disease	1	2
fm16	16. Hashimoto's Thyroiditis	1	2
fm17	17. Reiter's Syndrome	1	2

Study #021 Plate #351 Seq #005

Participant ID # ☐☐ – ☐☐☐☐ – ☐☐

Today's Date ☐☐ ☐☐ ☐☐ (day month year)

Follow-up Medical History Questionnaire

SYSTEMS REVIEW

Please indicate whether or not the following symptoms have significantly affected you in the last year (symptoms occurring at a greater frequency or severity than you would expect for your age):

Constitutional

		yes	no
fm18	18. Unintentional weight loss over 10 pounds/4.5 kilograms in the last year	1	2

Ears, Nose and Throat

		yes	no
fm19	19. Ringing in ears	1	2
fm20	20. Loss of hearing	1	2
fm21	21. Nosebleeds	1	2
fm22	22. Loss of smell	1	2
fm23	23. Dryness in nose	1	2
fm24	24. Loss of taste	1	2
fm25	25. Hoarse voice without a cold	1	2

Respiratory

		yes	no
fm26	26. Frequent coughing without a cold	1	2
fm27	27. Coughing of blood	1	2
fm28	28. Wheezing (asthma)	1	2
fm29	29. An abnormal chest x-ray	1	2
fm30	30. Shortness of breath	1	2
fm31	31. Awakening at night with shortness of breath	1	2

Study #021 Plate #352 Seq #005

Participant ID # ☐☐ – ☐☐☐☐ – ☐☐ **Today's Date** ☐☐ ☐☐ ☐☐ (day month year)

Follow-up Medical History Questionnaire
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Please indicate whether or not the following symptoms have significantly affected you in the last year (symptoms occurring at a greater frequency or severity than you would expect for your age):

		yes	no
fm32	32. Discomfort, pressure, a tight feeling, or pain in the chest	1	2
fm33	33. Cramps in your legs while walking	1	2

Gastrointestinal

		yes	no
fm34	34. Nausea	1	2
fm35	35. Vomiting of blood or coffee ground material	1	2
fm36	36. Frequent or severe heartburn	1	2
fm37	37. Stomach pain relieved by food or milk	1	2
fm38	38. Jaundice	1	2
fm39	39. Increasing constipation	1	2
fm40	40. Persistent diarrhea	1	2
fm41	41. Blood in stools	1	2

Genitourinary

		yes	no
fm42	42. Getting up at night to pass urine	1	2

Musculoskeletal

		yes	no
fm43	43. Joint stiffness in the morning, lasting for more than one hour	1	2
fm44	44. Joint pain or joint swelling	1	2
fm45	45. Unexplained pain in many areas of both your upper and lower body and both your right and left sides that lasted 3 months or more	1	2

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Participant ID # ☐☐ – ☐☐☐☐ – ☐☐

Today's Date ☐☐ ☐☐ ☐☐ (day month year)

Follow-up Medical History Questionnaire
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Please indicate whether or not the following symptoms have significantly affected you in the last year (symptoms occurring at a greater frequency or severity than you would expect for your age):

Skin

		yes	no
fm46	46. Easy bruising	1	2
fm47	47. Redness	1	2
fm48	48. Rash	1	2
fm49	49. Hives (itchy welts caused by allergic reaction)	1	2
fm50	50. Sun sensitivity (significant rash after sun exposure, but not sun burn)	1	2
fm51	51. Tightness	1	2
fm52	52. Hair loss	1	2
fm53	53. Color changes of fingers or toes when exposed to the cold (Raynaud's)	1	2

Neurological

		yes	no
fm54	54. Dizziness	1	2
fm55	55. Memory loss	1	2
fm56	56. Recurring severe headaches	1	2
fm57	57. Fainting or blackout spells	1	2

Upper Limbs

Do you experience these symptoms to an abnormal degree in one or both sides of your body?

		yes	no
fm58	58. Weakness of hands (e.g. to zip, button, handle coins, manipulate a key, or other hand weakness)	1	2
fm59	59. Weakness of fingers when clasping or grasping objects	1	2

Study #021 Plate #354 Seq #005

Participant ID # ☐☐ – ☐☐☐☐ – ☐☐ **Today's Date** ☐☐ day ☐☐ month ☐☐ year

Follow-up Medical History Questionnaire
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Please indicate whether or not the following symptoms have significantly affected you in the last year (symptoms occurring at a greater frequency or severity than you would expect for your age):

		yes	no
fm60	60. Weakness of shoulders and upper arms, for example, to lift objects from a high shelf, to comb your hair, or to bring your hands to your face as in washing or eating	1	2

Lower Limbs

Do you experience these symptoms to an abnormal degree in one or both sides of your body?

		yes	no
fm61	61. Weakness of the legs so that you slap your feet in walking or cannot carry your weight on your heels	1	2
fm62	62. Weakness of the legs so that you cannot walk on your toes or forefoot	1	2
fm63	63. Weakness of your thighs and hips so that you have difficulty (or inability) to climb or descend stairs, arise from a chair, sofa or toilet seat, and in these acts need to use your arms	1	2

Sensory Symptoms

Do you experience these symptoms in one region or over the surface of your body to an abnormal degree? Do not include the brief symptoms of "prickling" or "asleep numbness" and discomfort which come from lying too long on an arm, or sitting or lying too long in one position on a leg.

		yes	no	
fm64	64. Decrease (or inability) to feel the surface features, size, shape, or texture of what you touch	1	2	→ ***Go to item 65***

64a. **Mark all that apply:**

fm64a_le ☐ 1 In legs (feet are included) fm64a_mo ☐ 1 In mouth, face, or head

fm64a_ar ☐ 1 In arms (hands are included) fm64a_ot ☐ 1 In other parts of the body

		yes	no	
fm65	65. Decrease (or inability) to recognize hot from cold	☐	☐	→ ***Go to item 66***

65a. **Mark all that apply:**

fm65a_le ☐ 1 In legs (feet are included) fm65a_mo ☐ 1 In mouth, face, or head

fm65a_ar ☐ 1 In arms (hands are included) fm65a_ot ☐ 1 In other parts of the body

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Participant ID # ☐☐ – ☐☐☐☐ – ☐☐ **Today's Date** ☐☐ day ☐☐ month ☐☐ year

Follow-up Medical History Questionnaire
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Please indicate whether or not the following symptoms have significantly affected you in the last year (symptoms occurring at a greater frequency or severity than you would expect for your age):

fm66 66. Decrease (or inability) to feel pain, cuts, bruises, or injuries . . . . . yes ☐1 no ☐2 → ***Go to item 67***

66a. **Mark all that apply**:

fm66a_le ☐1 In legs (feet are included) fm66a_mo ☐1 In mouth, face, or head

fm66a_ar ☐1 In arms (hands are included) fm66a_ot ☐1 In other parts of the body

fm67 67. A more or less continuous "prickling" or "tingling" feeling with or without an asleep dead feeling . . . . . yes ☐1 no ☐2 → ***Go to item 68***

67a. **Mark all that apply**:

fm67a_le ☐1 In legs (feet are included) fm67a_mo ☐1 In mouth, face, or head

fm67a_ar ☐1 In arms (hands are included) fm67a_ot ☐1 In other parts of the body

fm68 68. Sharp "jabbing" needle-like pain or pulses of pain (lasting seconds or a minute or two) . . . . . yes ☐1 no ☐2 → ***Go to item 69***

68a. **Mark all that apply**:

fm68a_le ☐1 In legs (feet are included) fm68a_mo ☐1 In mouth, face, or head

fm68a_ar ☐1 In arms (hands are included) fm68a_ot ☐1 In other parts of the body

fm69 69. Persistent or frequent burning discomfort . . . . . yes ☐1 no ☐2 → ***End of Questionnaire***

69a. **Mark all that apply**:

fm69a_le ☐1 In legs (feet are included) fm69a_mo ☐1 In mouth, face, or head

fm69a_ar ☐1 In arms (hands are included) fm69a_ot ☐1 In other parts of the body

CLINIC USE ONLY

fm70 70. Was this questionnaire administered by study staff? . . . . . yes ☐1 no ☐2

Staff Initials ☐☐☐ Staff Signature and Date _____ 1.02