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Do you currently have a 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):

1. Type 1 Diabetes (Insulin dependent) .......................................................... 1 2
2. Type 2 Diabetes (Non-insulin dependent) .................................................. 1 2
3. Multiple Sclerosis ................................................................. Questions 3-17: Use summary variable (derived variable) "other_ai". Where Yes = autoimmune disease.
4. Behçet's Disease ................................................................. self-reported at least one systemic
5. Psoriasis ................................................................................. 1 2
6. Myasthenia Gravis........................................................................ 1 2
7. Vitiligo .................................................................................. 1 2
8. Pemphigus Vulgaris........................................................................ 1 2
9. Ulcerative Colitis ........................................................................ 1 2
10. Crohn's Disease ........................................................................ 1 2
11. Wegener's Granulomatosis ............................................................... 1 2
12. Discoid Lupus ........................................................................... 1 2
13. Ankylosing Spondylitis ........................................................................ 1 2
14. Pernicious or Hemolytic Anemia ...................................................... 1 2
15. Graves' Disease ........................................................................... 1 2
16. Hashimoto's Thyroiditis ................................................................. 1 2
17. Reiter's Syndrome ........................................................................ 1 2
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**

18. Unintentional weight loss over 10 pounds/4.5 kilograms in the last year.  

**Ears, Nose and Throat**

19. Ringing in ears.  
20. Loss of hearing  
21. Nosebleeds  
22. Loss of smell  
23. Dryness in nose  
24. Loss of taste  
25. Hoarse voice without a cold.

**Respiratory**

26. Frequent coughing without a cold .  
27. Coughing of blood .  
28. Wheezing (asthma) .  
30. Shortness of breath .  
31. Awakening at night with shortness of breath .

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**Results**

- 16 symptoms marked as yes
- 16 symptoms marked as no
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):

**Gastrointestinal**

- 32. Discomfort, pressure, a tight feeling, or pain in the chest
- 33. Cramps in your legs while walking
- 34. Nausea
- 35. Vomiting of blood or coffee ground material
- 36. Frequent or severe heartburn
- 37. Stomach pain relieved by food or milk
- 38. Jaundice
- 39. Increasing constipation
- 40. Persistent diarrhea
- 41. Blood in stools

**Genitourinary**

- 42. Getting up at night to pass urine

**Musculoskeletal**

- 43. Joint stiffness in the morning, lasting for more than one hour
- 44. Joint pain or joint swelling
- 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
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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

<table>
<thead>
<tr>
<th>bm46</th>
<th>46. Easy bruising</th>
<th>yes</th>
<th>no</th>
</tr>
</thead>
<tbody>
<tr>
<td>bm47</td>
<td>47. Redness</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>bm48</td>
<td>48. Rash</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>bm49</td>
<td>49. Hives (itchy welts caused by allergic reaction)</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>bm50</td>
<td>50. Sun sensitivity (significant rash after sun exposure, but not sun burn)</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>bm51</td>
<td>51. Tightness</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>bm52</td>
<td>52. Hair loss</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>bm53</td>
<td>53. Color changes of fingers or toes when exposed to the cold (Raynaud’s)</td>
<td>yes</td>
<td>no</td>
</tr>
</tbody>
</table>

### Neurological

<table>
<thead>
<tr>
<th>bm54</th>
<th>54. Dizziness</th>
<th>yes</th>
<th>no</th>
</tr>
</thead>
<tbody>
<tr>
<td>bm55</td>
<td>55. Memory loss</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>bm56</td>
<td>56. Recurring severe headaches</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>bm57</td>
<td>57. Fainting or blackout spells</td>
<td>yes</td>
<td>no</td>
</tr>
</tbody>
</table>

### Upper Limbs

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

<table>
<thead>
<tr>
<th>bm58</th>
<th>58. Weakness of hands (e.g. to zip, button, handle coins, manipulate a key, or other hand weakness)</th>
<th>yes</th>
<th>no</th>
</tr>
</thead>
<tbody>
<tr>
<td>bm59</td>
<td>59. Weakness of fingers when clasping or grasping objects</td>
<td>yes</td>
<td>no</td>
</tr>
</tbody>
</table>
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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):

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

61. Weakness of the legs so that you slap your feet in walking or cannot carry your weight on your heels

62. Weakness of the legs so that you cannot walk on your toes or forefoot

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

Sensory Symptoms

Do you experience these symptoms in one region or over the surface of your body to an abnormal degree?

64. Decrease (or inability) to feel the surface features, size, shape, or texture of what you touch

64a. Mark all that apply:

- In legs (feet are included)
- In mouth, face, or head
- In arms (hands are included)
- In other parts of the body

65. Decrease (or inability) to recognize hot from cold

65a. Mark all that apply:

- In legs (feet are included)
- In mouth, face, or head
- In arms (hands are included)
- In other parts of the body
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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):

66. Decrease (or inability) to feel pain, cuts, bruises, or injuries.

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

   - [ ] In legs (feet are included)
   - [ ] In arms (hands are included)
   - [ ] In mouth, face, or head
   - [ ] In other parts of the body

67. A more or less continuous “prickling” or “tingling” feeling with or without an asleep dead feeling

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

   - [ ] In legs (feet are included)
   - [ ] In arms (hands are included)
   - [ ] In mouth, face, or head
   - [ ] In other parts of the body

68. Sharp “jabbing” needle-like pain or pulses of pain (lasting seconds or a minute or two)

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

   - [ ] In legs (feet are included)
   - [ ] In arms (hands are included)
   - [ ] In mouth, face, or head
   - [ ] In other parts of the body

69. Persistent or frequent burning discomfort

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

   - [ ] In legs (feet are included)
   - [ ] In arms (hands are included)
   - [ ] In mouth, face, or head
   - [ ] In other parts of the body

70. Was this questionnaire administered by study staff?

   - [ ] Yes
   - [ ] No

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**CLINIC USE ONLY**

70. Was this questionnaire administered by study staff?

   - [ ] Yes
   - [ ] No