Baseline Questionnaire
Page 1 of 11

Demographics

bq1. Age: . . . . n n years

bq2. Gender: . . . 1 Female 2 Male

bq3. What is your highest level of schooling or education?

1. Primary or grammar school
2. Some high school
3. Graduated from high school
4. Some college or university education
5. Graduated from college or university
6. None

bq4. Which of the following best describes your current employment status?

1. Working full-time
2. Working part-time
3. Homemaker full-time
4. Retired
5. Student
6. Temporarily not working
7. Unable to work because of health reasons and/or disabled

Ethnic Background

5. What is your ethnicity? Mark all that apply.

bq5_ca 1 Caucasian
bq5_hi 1 Hispanic/Latino
bq5_na 1 Native American
bq5_as 1 Asian or Pacific Islander
bq5_af 1 African-American, Afro-Caribbean or other African Heritage
Baseline Questionnaire
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6. Please mark the ethnic origins of all of your biological grandparents (father’s father, father’s mother, mother’s father, and mother’s mother). **Mark all that apply.**

- Northern European
- Central European
- Southern European
- Eastern European
- Middle Eastern
- East Mediterranean
- North African
- Subsaharan African
- North American
- North American Indian
- Mexican
- Central American

Tobacco Use History

7. Do you currently smoke cigarettes? ........................................ yes  no  Go to item 10

8. Have you ever smoked cigarettes? ........................................ yes  no  Go to item 12

9. At what age did you stop smoking? ....................................... years

10. At what age did you start smoking? ...................................... years

11. Approximately how many cigarettes a day do/did you smoke? ........................... cigarettes per day

12. Do you use any other forms of tobacco? ................................. yes  no  Go to item 13

12a. Which of the following forms of tobacco do you use? **Mark all that apply.**

- Cigars
- Pipe
- Smokeless or chewing tobacco

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13. Do you use any other forms of nicotine? ............................

13a. Which of the following forms of nicotine do you use? Mark all that apply.

- Patch
- Chewing gum
- Other

General Physical and Emotional Health

These next questions are about your health now and your current daily activities. Please try to answer each question as accurately as you can.

14. In general, would you say your health is:

1. Excellent  
2. Very Good  
3. Good  
4. Fair  
5. Poor

*The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

15. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf

1. Yes, limited a lot  
2. Yes, limited a little  
3. No, not limited at all

16. Climbing several flights of stairs ........................................

1. Yes, limited a lot  
2. Yes, limited a little  
3. No, not limited at all

*During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

17. Accomplished less than you would like ..............................

1. All of the time  
2. Most of the time  
3. Some of the time  
4. A little of the time  
5. None of the time

18. Were limited in the kind of work or other activities ............

1. All of the time  
2. Most of the time  
3. Some of the time  
4. A little of the time  
5. None of the time

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*During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

**bq19** *19. Accomplished less than you would like* ................. 1 2 3 4 5

**bq20** *20. Did work or other activities less carefully than usual* .... 1 2 3 4 5

**bq21** *21. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

1 Not at all 4 Quite a bit
2 A little bit 5 Extremely
3 Moderately

*These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks...*

**bq22** *22. Have you felt calm and peaceful?* ......................... 1 2 3 4 5

**bq23** *23. Did you have a lot of energy?* .......................... 1 2 3 4 5

**bq24** *24. Have you felt downhearted and depressed?* .......... 1 2 3 4 5

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**Baseline Questionnaire**  
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25. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

1. All of the time  
2. Most of the time  
3. Some of the time  
4. A little bit of the time  
5. None of the time

Over the last 2 WEEKS how often have you felt bothered by the following problems:

26. Little interest or pleasure doing things

1. Not at all  
2. Several days  
3. More than half the days  
4. Nearly every day

27. Feeling down, depressed or hopeless

1. Not at all  
2. Several days  
3. More than half the days  
4. Nearly every day

28. Trouble falling or staying asleep, or sleeping too much

1. Not at all  
2. Several days  
3. More than half the days  
4. Nearly every day

29. Feeling tired or having little energy

1. Not at all  
2. Several days  
3. More than half the days  
4. Nearly every day

30. Poor appetite or overeating

1. Not at all  
2. Several days  
3. More than half the days  
4. Nearly every day

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31. Feeling bad about yourself, or that you are a failure or have let yourself or your family down
   1. Not at all
   2. Several days
   3. More than half the days
   4. Nearly every day

32. Trouble concentrating on things, such as reading the newspaper or watching television
   1. Not at all
   2. Several days
   3. More than half the days
   4. Nearly every day

33. Moving or speaking so slow that other people could have noticed.  
   Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual
   1. Not at all
   2. Several days
   3. More than half the days
   4. Nearly every day

34. Thoughts that you would be better off dead, or of hurting yourself in some way
   1. Not at all
   2. Several days
   3. More than half the days
   4. Nearly every day

**Reproductive and Hormonal History**
To be completed by women only. Men go to item 44.

35. How old were you when you first began having you menstrual period? ....... n n years

36. Have you started or experienced menopause? ................................. 1 2 Go to item 38

37. How old were you at the start of menopause? ................................. n n years

38. Have you had significant vaginal dryness? ................................. yes no

39. How many times have you been pregnant in your lifetime? ................. n n  If 0, go to item 42
   Please include live births, still births, terminations/abortions, miscarriages and tubal pregnancies.
Baseline Questionnaire
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40. How many of these pregnancies resulted in:

40a. Full-term delivery? ............................................................... n n

40b. Premature delivery (more than 3 weeks before due date)? ............ n n

40c. Miscarriage during the 1st trimester? ........................................ n n

40d. Miscarriage during the 2nd trimester? ....................................... n n

40e. Stillbirth during the 3rd trimester? .......................................... n n

41. Have you ever had a child born with complete congenital heart block? .... yes no

42. Do you currently take female hormones (birth control pills, estrogen and/or progestins as pills, patches or injections, etc.)?

43. Have you had a hysterectomy? ................................................... yes no

Symptoms Affecting Your Mouth

44. Does your mouth feel dry? ......................................................... yes no

44a. When does your mouth feel dry? *Mark all that apply.*

☐ In the morning
☐ In the afternoon
☐ At night

44b. When did your mouth first start feeling dry? ............................... month n n year n n

45. Does your mouth feel dry when eating a meal? .............................. yes no

46. Do you have difficulty swallowing any foods? ............................... yes no

47. Do you need to sip liquids to swallow dry foods? ........................... yes no

SICCA BQ v1.04 - Jan 16, 2007
54. In general, how often do you floss your teeth?
   1. Never  2. Occasionally  3. Once per day  4. More than once a day

55. How often do you clean between your teeth with a toothpick?
   1. Never  2. Occasionally  3. Once per day  4. More than once a day

56. In the past year, have you avoided eating certain foods you wanted because . . . . . . . . .
   yes  no
   1  2

They made your mouth hurt.
57. Have you experienced any change/loss in your sense of taste?  

58. Do you have a regular source of dental care - that is, a dentist or dental clinic that you visit on a regular basis to get your teeth examined, cleaned, or cared for?

59. About how long has it been since you were last treated or examined by a dentist or a hygienist?

1 Less than 3 months  
2 3 to 6 months  
3 6 to 12 months  
4 1-2 years  
5 2-3 years  
6 3-5 years  
7 More than 5 years  
8 Never

60. Approximately how many times have you visited the dentist in the past year?

1 0  
2 1  
3 2  
4 3  
5 4  
6 5  
7 6 or more

61. During the past 12 months have you had any of the following dental procedures? *Mark all that apply.*

- Oral examination  
- Radiographs or x-rays of the teeth  
- Teeth cleaned by a dentist or hygienist  
- A tooth or teeth removed  
- Any gum treatment or gum surgery  
- A biopsy taken from your mouth or lip  
- A tooth filled or crown made  
- None

Symptoms Affecting Your Eyes

62. Do your eyes feel dry?   

62a. When do your eyes feel dry? *Mark all that apply.*

- In the morning  
- In the afternoon  
- At night

62b. When did your eyes first start feeling dry?   

- Month   
- Year

SICCA BQ v1.04 - Jan 16, 2007
### Baseline Questionnaire (BQ10)

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**Today's Date**

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<td>4</td>
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**Participant ID #**

- n n n n n n n id_039

#### 63. How often do you have redness in your eyes? (None of the time | Some of the time | Half of the time | Most of the time | All of the time)

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#### 64. How often do your eyes itch? (None of the time | Some of the time | Half of the time | Most of the time | All of the time)

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#### 65. How often do you have excessive tears? (Yes | No)

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#### 66. Are you able to produce tears? (Yes | No)

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#### 67. How often do you use artificial tears?

- 1 10 times a day or more
- 3 1 to 3 times a day
- 2 4 to 9 times a day
- 4 Never

67a. What type of artificial tears do you use? **Mark all that apply.**

- Bottles (with preservatives)
- Single vials (without preservatives)
- Ointment
- Don’t know

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67b. Does your vision improve with artificial tears? (Yes | No)

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#### 68. Do you use any other type of medicated drops in your eyes? (None of the time | Some of the time | Half of the time | Most of the time | All of the time)

- Whitening
- Vasoconstrictor
- Cyclosporine/Restasis
- Traditional
- Steroid
- Other

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#### 69. During the LAST WEEK have you experienced any of the following symptoms with your eyes:

69a. Light sensitivity

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69b. Gritty or scratchy sensation

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69c. Burning or stinging

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### Baseline Questionnaire

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<tr>
<th>Question</th>
<th>Options</th>
<th>Selection</th>
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<tr>
<td><strong>69d. Blurred vision.</strong></td>
<td>None</td>
<td>Most</td>
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<td><strong>69e. Vision that fluctuates with blinking.</strong></td>
<td>None</td>
<td>Most</td>
</tr>
<tr>
<td><strong>69f. Tearing.</strong></td>
<td>None</td>
<td>Most</td>
</tr>
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<td><strong>69g. Pain or burning in the middle of the night or upon waking in the morning.</strong></td>
<td>None</td>
<td>Most</td>
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<tr>
<td><strong>70. Have you experienced eye irritation while performing any of these activities during the last week:</strong></td>
<td>None</td>
<td>Most</td>
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<tr>
<td><strong>71a. Wind or air drafts.</strong></td>
<td>None</td>
<td>Most</td>
</tr>
<tr>
<td><strong>71b. Places with low humidity such as air conditioned or heated buildings or airplanes.</strong></td>
<td>None</td>
<td>Most</td>
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<tr>
<td><strong>72. Have any of your immediate blood related family members (see below) been diagnosed with Sjögren’s Syndrome?</strong></td>
<td>Yes</td>
<td>No</td>
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<tr>
<td><strong>72a. Which family member(s)? Mark all that apply.</strong></td>
<td>Mother</td>
<td>Father</td>
</tr>
</tbody>
</table>

**CLINIC USE ONLY**

**73. Was this questionnaire administered by study staff?** | Yes | No |