MEDICAL HISTORY

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):

1. Type 1 Diabetes (Insulin dependent) ................................................. yes no
2. Type 2 Diabetes (Non-insulin dependent) ......................................... yes no
3. Multiple Sclerosis ................................................................. yes no
4. Behçet's Disease ............................................................... yes no
5. Psoriasis ............................................................... yes no
6. Myasthenia Gravis ............................................................... yes no
7. Vitiligo ............................................................... yes no
8. Pemphigus Vulgaris ............................................................... yes no
9. Ulcerative Colitis ............................................................... yes no
10. Crohn's Disease .............................................................. yes no
11. Wegener's Granulomatosis .............................................................. yes no
12. Discoid Lupus ............................................................... yes no
13. Ankylosing Spondylitis ............................................................... yes no
14. Pernicious or Hemolytic Anemia .............................................................. yes no
15. Graves' Disease ............................................................... yes no
16. Hashimoto's Thyroiditis ............................................................... yes no
17. Reiter's Syndrome .............................................................. yes no
Follow-up Medical History Questionnaire
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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

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)

29. An abnormal chest x-ray

30. Shortness of breath

31. Awakening at night with shortness of breath
Follow-up Medical History Questionnaire

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):

<p>| | | | | |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>32. Discomfort, pressure, a tight feeling, or pain in the chest</td>
<td>yes</td>
<td>no</td>
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<tr>
<td>33. Cramps in your legs while walking.</td>
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<td>34. Nausea.</td>
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<td>35. Vomiting of blood or coffee ground material</td>
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<td>36. Frequent or severe heartburn</td>
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<td>37. Stomach pain relieved by food or milk.</td>
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<td>38. Jaundice.</td>
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<td>39. Increasing constipation</td>
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<td>40. Persistent diarrhea.</td>
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<td>41. Blood in stools.</td>
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<td>42. Getting up at night to pass urine</td>
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<td>43. Joint stiffness in the morning, lasting for more than one hour</td>
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<td>44. Joint pain or joint swelling</td>
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<tr>
<td>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</td>
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</table>

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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

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

### Neurological

<table>
<thead>
<tr>
<th>Symptom</th>
<th>yes</th>
<th>no</th>
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<tbody>
<tr>
<td>54. Dizziness</td>
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<td>55. Memory loss</td>
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<td></td>
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<td>56. Recurring severe headaches</td>
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<td>57. Fainting or blackout spells</td>
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</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>Symptom</th>
<th>yes</th>
<th>no</th>
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</thead>
<tbody>
<tr>
<td>58. Weakness of hands (e.g. to zip, button, handle coins, manipulate a key, or other hand weakness)</td>
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<tr>
<td>59. Weakness of fingers when clasping or grasping objects</td>
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</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):

**Lower Limbs**

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

**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

**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.

**fm64** 64. Decrease (or inability) to feel the surface features, size, shape, or texture of what you touch

**fm64a** 64a. Mark all that apply:

- **fm64a_le** In legs (feet are included)
- **fm64a_mo** In mouth, face, or head
- **fm64a_ar** In arms (hands are included)
- **fm64a_ot** In other parts of the body

**fm65** 65. Decrease (or inability) to recognize hot from cold

**fm65a** 65a. Mark all that apply:

- **fm65a_le** In legs (feet are included)
- **fm65a_mo** In mouth, face, or head
- **fm65a_ar** In arms (hands are included)
- **fm65a_ot** In other parts of the body
Follow-up Medical History Questionnaire

Page 6 of 6

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

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

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

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

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CLINIC USE ONLY

70. Was this questionnaire administered by study staff?  
   - yes
   - no

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Staff Initials

Staff Signature and Date