



**5. Please check (✓) if you have experienced any of the following over the last month:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Fever                        | <input type="checkbox"/> Lump in your throat             | <input type="checkbox"/> Paralysis of arms or legs            |
| <input type="checkbox"/> Weight gain (>10 lbs)        | <input type="checkbox"/> Cough                           | <input type="checkbox"/> Numbness or tingling of arms or legs |
| <input type="checkbox"/> Weight loss (>10 lbs)        | <input type="checkbox"/> Shortness of breath             | <input type="checkbox"/> Fainting spells                      |
| <input type="checkbox"/> Feeling sickly               | <input type="checkbox"/> Wheezing                        | <input type="checkbox"/> Swelling of hands                    |
| <input type="checkbox"/> Headaches                    | <input type="checkbox"/> Pain in the chest               | <input type="checkbox"/> Swelling of ankles                   |
| <input type="checkbox"/> Unusual fatigue              | <input type="checkbox"/> Heart pounding (palpitations)   | <input type="checkbox"/> Swelling in other joints             |
| <input type="checkbox"/> Swollen glands               | <input type="checkbox"/> Trouble swallowing              | <input type="checkbox"/> Joint pain                           |
| <input type="checkbox"/> Loss of appetite             | <input type="checkbox"/> Heartburn or stomach gas        | <input type="checkbox"/> Back pain                            |
| <input type="checkbox"/> Skin rash or hives           | <input type="checkbox"/> Stomach pain or cramps          | <input type="checkbox"/> Neck pain                            |
| <input type="checkbox"/> Unusual bruising or bleeding | <input type="checkbox"/> Nausea                          | <input type="checkbox"/> Use of drugs not sold in stores      |
| <input type="checkbox"/> Other skin problems          | <input type="checkbox"/> Vomiting                        | <input type="checkbox"/> Smoking cigarettes                   |
| <input type="checkbox"/> Loss of hair                 | <input type="checkbox"/> Constipation                    | <input type="checkbox"/> More than 2 alcoholic drinks per day |
| <input type="checkbox"/> Dry eyes                     | <input type="checkbox"/> Diarrhea                        | <input type="checkbox"/> Depression - feeling blue            |
| <input type="checkbox"/> Other eye problems           | <input type="checkbox"/> Dark or bloody stools           | <input type="checkbox"/> Anxiety - feeling nervous            |
| <input type="checkbox"/> Problems with hearing        | <input type="checkbox"/> Problems with urination         | <input type="checkbox"/> Problems with thinking               |
| <input type="checkbox"/> Ringing in the ears          | <input type="checkbox"/> Gynecological (female) problems | <input type="checkbox"/> Problems with memory                 |
| <input type="checkbox"/> Stuffy nose                  | <input type="checkbox"/> Dizziness                       | <input type="checkbox"/> Problems with sleeping               |
| <input type="checkbox"/> Sores in the mouth           | <input type="checkbox"/> Losing your balance             | <input type="checkbox"/> Sexual problems                      |
| <input type="checkbox"/> Dry mouth                    | <input type="checkbox"/> Muscle pain, aches, or cramps   | <input type="checkbox"/> Burning in sex organs                |
| <input type="checkbox"/> Problems with smell or taste | <input type="checkbox"/> Muscle weakness                 | <input type="checkbox"/> Problems with social activities      |

<b>FOR OFFICE USE ONLY</b>
5. Sx 1st <input type="checkbox"/>
9. FTG <input type="checkbox"/>
FAST3-P <input type="checkbox"/>
FAST4 <input type="checkbox"/>

**Please check (✓) here if you have had none of the above over the last month: \_\_\_\_\_.**

**6. When you woke up in the morning OVER THE LAST WEEK, did you feel stiff?  No  Yes**

If "No," please go to Item 7. If "Yes," **please indicate the number of minutes \_\_\_\_\_, or hours \_\_\_\_\_** until you are as limber as you will be for the day.

**7. How do you feel TODAY compared to ONE WEEK AGO? Please check (✓) only one.**

Much Better · (1), Better · (2), the Same · (3), Worse · (4), Much Worse · (5) than one week ago

**8. How often do you exercise aerobically (sweating, increased heart rate, shortness of breath) for at least one-half hour (30 minutes)? Please check (✓) only one.**

- 3 or more times a week (3)     1-2 times per month (1)  
 1-2 times per week (2)     Do not exercise regularly (0)     Cannot exercise due to disability/ handicap (9)

**9. How much of a problem has UNUSUAL fatigue or tiredness been for you OVER THE PAST WEEK?**

FATIGUE IS                       FATIGUE IS A  
 NO PROBLEM    0    0.5    1.0    1.5    2.0    2.5    3.0    3.5    4.0    4.5    5.0    5.5    6.0    6.5    7.0    7.5    8.0    8.5    9.0    9.5    10    MAJOR PROBLEM

**10. Over the last 6 months have you had: [Please check (✓)]**

- |   |  |
|---|--|
| <input type="checkbox"/> No <input type="checkbox"/> Yes An operation or new illness                      | <input type="checkbox"/> No <input type="checkbox"/> Yes Change(s) of arthritis or other medication    |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Medical emergency or stay overnight in hospital  | <input type="checkbox"/> No <input type="checkbox"/> Yes Change(s) of address                          |
| <input type="checkbox"/> No <input type="checkbox"/> Yes A fall, broken bone, or other accident or trauma | <input type="checkbox"/> No <input type="checkbox"/> Yes Change(s) of marital status                   |
| <input type="checkbox"/> No <input type="checkbox"/> Yes An important new symptom or medical problem      | <input type="checkbox"/> No <input type="checkbox"/> Yes Change job or work duties, quit work, retired |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Side effect(s) of any medication or drug         | <input type="checkbox"/> No <input type="checkbox"/> Yes Change of medical insurance, Medicare, etc.   |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Smoke cigarettes regularly                       | <input type="checkbox"/> No <input type="checkbox"/> Yes Change of primary care or other doctor        |

**Please explain any "Yes" answer below, or indicate any other health matter that affects you:**

**SEX:**  Female,  Male    **ETHNIC GROUP:**  Asian,  Black,  Hispanic,  White,  Other \_\_\_\_\_

**Your Occupation** \_\_\_\_\_ **Please circle the number of years of school you have completed:**

**Work Status:**  Full-time,  Part-time,  Disabled    1    2    3    4    5    6    7    8    9    10  
 Homemaker,  Self-Employed,  Retired,    11    12    13    14    15    16    17    18    19    20

Seeking work,  Other \_\_\_\_\_ **Please write your weight: \_\_\_\_\_ lbs. height: \_\_\_\_\_ feet \_\_\_\_\_ inches**

**Your Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_ **Today's Date** \_\_\_\_\_

**Page 2 of 2 Thank you for completing this questionnaire to help keep track of your medical care. R801.16NP2**

<b>FOR OFFICE USE ONLY:</b> I have reviewed the questionnaire responses.	
Date: _____	Signature _____