Center for Hypotension
Autonomic Questionnaire

Revised 12/3/09

Name:_______________________________________**Today's Date:**_________

Birth Date: _______________ **Age:** ___________ **Gender:** M F

Height: __________________ **Weight:** _________

Address:____

City/State/Zip Code:____

Social Security Number: ____

Telephone: Home: ____________________________

Work: ____________________________

Cell: ____________________________

Email Address:____

Ethnicity:

_____ Hispanic/ Latino _____ Non-Hispanic/Latino

Race:

_____ American Indian/Alaska Native _____ Asian

_____ Native Hawaiian or Other Pacific Islander _____ Black or African American

_____ White/Caucasian

1. Are you currently working or going to school?

Yes_____ No_____

2. If you work, what is your current occupation?

____

3. How many days of work or school have you missed in the last month because of your illness?

____

4. If no, when did you last work or attend school? Please explain.

____

____

5. Do you have any allergies? Please be specific (medication, food, other):

____
____
____

6. Have you been told that you have a disorder of the autonomic nervous system?

Yes_____ No_____

7. If so, by whom?

____

8. What is/was the disorder called?

____

9. List your medical problems (e.g., diabetes, high blood pressure, asthma, kidney disease, stroke, cancer, heart disease, etc.)

____
____
____

Do you smoke? Yes____No______ If yes, how much___________

Primary Physician's Name:____

Primary Physician's Address and phone number:

____
____

10. Do you believe you have or have you been told that you have one of the following conditions? (Circle all that apply)

a. mitral valve prolapse
b. fibromyalgia
c. sick building syndrome
d. multiple chemical sensitivity
e. chronic fatigue syndrome
f. irritable bowel syndrome
g. hypoglycemia
h. dysautonomia

11. Please list any diseases or disorders that you have been diagnosed with and dates (specifically month and year):

____
____
____
____
____

12. Which of your problems is most troubling to you?

____

13. What do you hope to get from your visit?

____

14. When and how did your current symptoms begin?

____

7. Has a psychiatrist or other health professional ever said that you have (check if yes):

( ) depression
( ) bipolar disorder (manic depressive disorder)
( ) schizophrenia
( ) anorexia nervosa
( ) bulimia
( ) panic attacks
( ) anxiety disorder
( ) other diagnosis ______________________________

15. Please list any medications that you are taking (this includes over the counter drugs like Tylenol and Advil and herbal or nutritional supplements):

Name	Dose (mg)	Times per day

Use the scale below to complete the list regarding your symptoms and their frequency per month:

1: Never **2:** 1 time **3:** 2-4 times **4:** 5-7 times **5:** daily (Please number daily occurrences in the space provided)

1 2 3 4 5 ______ urinary incontinence or leaking

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1	2	3	4	5	_______	constipation
1	2	3	4	5	_______	fatigue
1	2	3	4	5	_______	nausea
1	2	3	4	5	_______	headache
1	2	3	4	5	_______	heartburn
1	2	3	4	5	_______	clamminess of skin
1	2	3	4	5	_______	tremulousness
1	2	3	4	5	_______	impotence (for males)
1	2	3	4	5	_______	sensation of rapid heartbeat
1	2	3	4	5	_______	impaired memory
1	2	3	4	5	_______	fainting
1	2	3	4	5	_______	itching of the feet
1	2	3	4	5	_______	chest discomfort
1	2	3	4	5	_______	sensation of forceful, slow heartbeat
1	2	3	4	5	_______	dizziness
1	2	3	4	5	_______	feeling of weakness
1	2	3	4	5	_______	frequent wakening during the night
1	2	3	4	5	_______	shortness of breath
1	2	3	4	5	_______	blurring or dimming of vision
1	2	3	4	5	_______	difficulty emptying the bladder
1	2	3	4	5	_______	excessive daytime sleepiness
1	2	3	4	5	_______	loose, watery stools
1	2	3	4	5	_______	anxiety
1	2	3	4	5	_______	muscle aches
1	2	3	4	5	_______	bloating after meals
1	2	3	4	5	_______	itching of the hands
1	2	3	4	5	_______	lightheadedness (faintness)
1	2	3	4	5	_______	difficulty falling to sleep
1	2	3	4	5	_______	difficulty with starting to urinate
1	2	3	4	5	_______	sensation of head or room spinning
1	2	3	4	5	_______	excessive sweating
1	2	3	4	5	_______	confusion
1	2	3	4	5	_______	neck or shoulder aching
1	2	3	4	5	_______	joint aches
1	2	3	4	5	_______	difficulty staying asleep
1	2	3	4	5	_______	facial flushing
1	2	3	4	5	_______	vomiting
1	2	3	4	5	_______	diarrhea
1	2	3	4	5	_______	Pale or Gray color to your face
1	2	3	4	5	_______	discolored hands or feet
1	2	3	4	5	_______	cold hands or feet
1	2	3	4	5	_______	pain in hands, feet, legs

16. Please list your 3 main symptoms:

a) ______________________________

b) ______________________________

c) ______________________________

17. <u>How frequent are these symptoms?</u>

[ ] Never or almost never
[ ] Several times a month
[ ] Several times a week
[ ] Daily

18. <u>How severe are these symptoms?</u>

[ ] Mild
[ ] Moderate
[ ] Severe

19. <u>How long have you had symptoms?</u>

[ ] Less than 1 month
[ ] 1-3 months
[ ] 6-12 months
[ ] More than 1 year

20. <u>Are they improving?</u>

[ ] Yes
[ ] No
[ ] No change

21. <u>Does anyone else in the family have these symptoms? Who?</u>

____
____
____
____

22. <u>Which of your mother/father/sister/brother have had</u>:

a) Diabetes______________________________

b) High blood pressure______________________________

c) Asthma______________________________

d) Heart disease____

e) Kidney disease____

f) Stroke____

g) Cancer____

h) Other disease____

23. <u>If you were frequently dizzy, did this begin before the illness?</u> [ ] Yes [ ] No

24. <u>Have you ever fainted (unconscious)</u>? [ ] Yes [ ] No

25. <u>Have you ever nearly fainted (not unconscious but blackout, or fell down from dizziness)</u>? [ ] Yes [ ] No

26. <u>If you fainted or nearly fainted, did this begin before the illness</u>? [ ] Yes [ ] No

27. <u>If you have fainted, nearly fainted or been frequently (daily) dizzy is this related to exercise</u>? *(check only one answer)*

[ ] Mostly or always occurs with exercise but not at rest
[ ] Can occur without exercise but exercise makes it worse
[ ] Not related to exercise

28. <u>Does fainting or dizziness occur when you are standing or sitting</u>?
[ ] Always
[ ] Almost always
[ ] Never
[ ] Not related to posture

29. <u>Does fainting or dizziness get better when you lie down</u>? [ ] Yes [ ] No

30. <u>Does fainting or dizziness worsen with emotion or fear?</u> [ ] Yes [ ] No

31. <u>Are you bedridden</u>? [ ] Yes [ ] No

If yes for how long and explain ____

32. Which statement below best describes your usual desire for salt
(*check only one answer*)
[ ] I have no special craving for salt
[ ] I occasionally have a craving for salt and salty foods
[ ] I often crave salt and salty foods

33. Which statement below best describes your usual degree of thirst and fluid consumption (*check only one answer*)

[ ] I am thirsty all the time and drink frequently
[ ] I am thirsty all the time but drink a normal amount
[ ] I am normally thirsty and drink frequently
[ ] I am normally thirsty and drink a normal amount
[ ] I am rarely thirsty and drink frequently
[ ] I am rarely thirsty and drink a normal amount
[ ] I am rarely thirsty and drink infrequently

34. How long have you had symptoms? (*check only one answer*)
[ ] Less than 1 month
[ ] 1-3 months
[ ] 6-12 months
[ ] More than 1 year

35. How often do you get the following symptoms:

a) Feeling full after eating just a small amount of food
[ ] Never or almost never
[ ] Several times a month
[ ] Several times a week
[ ] Daily

b) Sensation that food is coming back up from your stomach
[ ] Never or almost never
[ ] Several times a month
[ ] Several times a week
[ ] Daily

c) Pain in the upper abdomen
[ ] Never or almost never
[ ] Several times a month
[ ] Several times a week
[ ] Daily

d) Facial Flushing

[ ] Never or almost never
[ ] Several times a month
[ ] Several times a week
[ ] Daily

e) Are your other symptoms worsened by environmental heat?

[ ] Never or almost never
[ ] Several times a month
[ ] Several times a week
[ ] Daily

f) Do your symptoms occur when you are standing or sitting?

[ ] Always
[ ] Almost always
[ ] Never
[ ] Not related to posture

g) Do your symptoms get better when you lie down?

[ ] Yes [ ] No

h) Do your symptoms get worse with exercise?

[ ] Yes [ ] No

i) Do your symptoms get worse with alcohol?

[ ] Yes [ ] No

j) Do your symptoms change during the menstrual cycle?

[ ] Yes [ ] No

k) **Are these symptoms related to dizziness or fainting?**

[ ] Yes [ ] No

l) Are these symptoms related to any specific medication that you take?

[ ] Yes [ ] No

m) Please explain any abnormal findings:

____
____
____
____
____
____

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Heart Rate and Blood Pressure Recordings
Please record your blood pressure and heart rate under the following conditions on three separate occasions. Lie quietly for 10 minutes and then take blood pressure and heart rate. Then stand in one place. Take blood pressure and heart rate at the end of 3 minutes and then again at 10 minutes. Record the results below. **This is VERY IMPORTANT. These records cannot be properly evaluated without this information.**

		blood pressure	heart rate
date_______ time______	lying		
	standing 3 min		
	standing 10 min		
date_______ time______	lying		
	standing 3 min		
	standing 10 min		
date_______ time______	lying		
	standing 3 min		
	standing 10 min		

How were these readings taken? ____

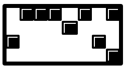
Who measured your blood pressure and heart rate? _________________________

Does the cuff automatically make the measurements? _________________________

Did you use an arm cuff or finger cuff? _____________________________________

Please return this questionnaire to:

Courtney Terilli, RN, BSN
Research Coordinator
Center for Hypotension
New York Medical College
19 Bradhurst Avenue Suite 1600 South
Hawthorne NY 10532
Email: courtney_terilli@nymc.edu
Ph: (914) 593-8888
Fax: (914) 593-8890



2178

AUTONOMIC SYMPTOM PROFILE

Answer every question by darkening the appropriate oval. If you are unsure about how to answer a question, please give the best answer you can.

MARKING INSTRUCTIONS

Use a NO. 2 pencil.
Darken the corresponding oval completely.
Fill in the number in the box if provided.
Erase completely any marks you wish to change.

Clinic Number

☐☐-☐☐☐-☐☐☐

1	○ ○	○ ○ ○	○ ○ ○
2	○ ○	○ ○ ○	○ ○ ○
3	○ ○	○ ○ ○	○ ○ ○
4	○ ○	○ ○ ○	○ ○ ○
5	○ ○	○ ○ ○	○ ○ ○
6	○ ○	○ ○ ○	○ ○ ○
7	○ ○	○ ○ ○	○ ○ ○
8	○ ○	○ ○ ○	○ ○ ○
9	○ ○	○ ○ ○	○ ○ ○
0	○ ○	○ ○ ○	○ ○ ○

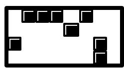
Today's Date

☐☐/☐☐/☐☐☐☐

1	○ ○	○ ○	○ ○ ○ ○
2	○ ○	○ ○	○ ○ ○ ○
3	○ ○	○ ○	○ ○ ○ ○
4	○ ○	○ ○	○ ○ ○ ○
5	○ ○	○ ○	○ ○ ○ ○
6	○ ○	○ ○	○ ○ ○ ○
7	○ ○	○ ○	○ ○ ○ ○
8	○ ○	○ ○	○ ○ ○ ○
9	○ ○	○ ○	○ ○ ○ ○
0	○ ○	○ ○	○ ○ ○ ○

Diagnosis

____



18. In the past year, have you ever felt faint, dizzy, or "goofy" or had difficulty thinking soon after standing up from a sitting or lying down position?

- ○ 1 **Yes** *If you marked YES go to question 19.*
- ○ 2 **No** If you marked No go to question 37.

19. When standing up, how frequently do you get these feelings or symptoms?

- ○ 1 **Rarely**
- ○ 2 **Occasionally**
- ○ 3 **Frequently**
- ○ 4 **Almost always**

20. How would you rate the severity of these feelings or symptoms?

- ○ 1 **Mild**
- ○ 2 **Moderate**
- ○ 3 **Severe**

21. For how long have you been experiencing these feelings or symptoms?

- ○ 1 **Less than 3 months**
- ○ 2 **3 to 6 months**
- ○ 3 **7 to 12 months**
- ○ 4 **13 months to 5 years**
- ○ 5 **More than 5 years**
- ○ 6 **As long as I can remember**

22. In the past year, how often have you ended up fainting soon after standing up from a sitting or lying down position?

- ○ 0 Never
- ○ 1 Once
- ○ 2 Twice
- ○ 3 Three times
- ○ 4 Four times
- ○ 5 Five or more times

23. How cautious are you about standing up from a sitting or lying down position?

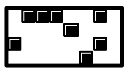
- ○ 1 Not cautious at all
- ○ 2 Somewhat cautious
- ○ 3 Extremely cautious

24. What part of the day are these feelings worse? (Check only one)

- ○ 1 Early morning
- ○ 2 Rest of morning
- ○ 3 Afternoon
- ○ 4 Evening
- ○ 5 At night, when I get up after I've been asleep
- ○ 6 No particular time is worse
- ○ 7 Other time, please specify________________________________

25. In the past year, have these feelings or symptoms that you have experienced:

- ○ 1 Gotten much worse
- ○ 2 Gotten somewhat worse
- ○ 3 Stayed about the same
- ○ 4 Gotten somewhat better
- ○ 5 Gotten much better
- ○ 6 Completely gone



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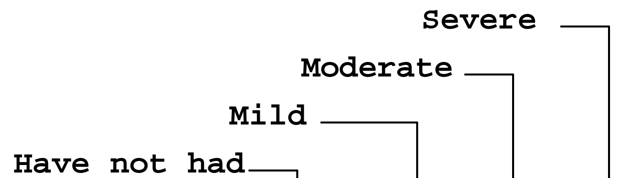
Please rate the average severity you have experienced in the past year for each of the following symptoms.



	Have not had	Mild	Moderate	Severe
26. Rapid or increased heart rate? (palpitations)	1 ○	2 ○	3 ○	4 ○
27. Sickness to your stomach(nausea) or vomiting?	1 ○	2 ○	3 ○	4 ○
28. A spinning or swimming sensation?	1 ○	2 ○	3 ○	4 ○
29. Dizziness?	1 ○	2 ○	3 ○	4 ○
30. Blurred vision?	1 ○	2 ○	3 ○	4 ○
31. Feeling of weakness?	1 ○	2 ○	3 ○	4 ○
32. Feeling shaky or shaking sensation?	1 ○	2 ○	3 ○	4 ○
33. Feeling anxious or nervous?	1 ○	2 ○	3 ○	4 ○
34. Turning pale?	1 ○	2 ○	3 ○	4 ○
35. Clammy feeling to your skin?	1 ○	2 ○	3 ○	4 ○

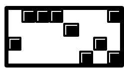
36. Do you have any biological (blood,natural) relatives among your parents, grandparents, brothers, sisters, or children who have frequent dizziness after standing from a sitting or lying down position?

○ 1 Yes

○ 2 No

If Yes, please list their names and relationship to you.

Name	Relationship
______________________	____________________
______________________	____________________
______________________	____________________
______________________	____________________



In the past year, have you ever felt faint, dizzy, or "goofy" or had difficulty thinking:

37. soon after a meal? ○ 1 **Yes** ○ 2 **No**

38. after standing for a long time? ○ 1 **Yes** ○ 2 **No**

39. during or soon after physical activity or exercise? ○ 1 **Yes** ○ 2 **No**

40. during or soon after being in a hot bath, shower, tub, or sauna? ○ 1 **Yes** ○ 2 **No**

41. Have you ever felt dizzy or faint or actually fainted when you saw blood or had a blood sample taken?

○ 1 **Yes** ○ 2 **No**

In the past year, have you fainted:

42. while passing urine? ○ 1 **Yes** ○ 2 **No**

43. while coughing? ○ 1 **Yes** ○ 2 **No**

44. while pressing on side of neck? ○ 1 **Yes** ○ 2 **No**

45. before a public speech? ○ 1 **Yes** ○ 2 **No**

46. any other time? ○ 1 **Yes** ○ 2 **No**

If you checked "Yes" to any of these questions on fainting, please describe circumstances.

____

____

47. In the past year, have you ever completely lost consciousness after a spell of dizziness?

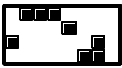
○ 1 **Yes** ○ 2 **No**

48. In the past year, have you had any seizures or convulsions?

○ 1 **Yes** please describe circumstances below

○ 2 **No** ____

____



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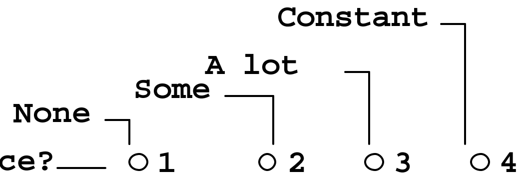
In the past 5 years how would rate the amount of trouble, if any, you have had:



49. with paralysis in parts of your face? ○ 1 ○ 2 ○ 3 ○ 4

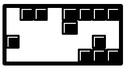
50. with feelings of complete weakness all over your body? ○ 1 ○ 2 ○ 3 ○ 4

51. with attacks of uncontrollable movements of your arms or legs? ○ 1 ○ 2 ○ 3 ○ 4

52. with attacks in which you couldn't control your speech? ○ 1 ○ 2 ○ 3 ○ 4

53. Have you ever in your adult life had a spell of dizziness?

○ 1 Yes ○ 2 No



2178

54. In the past year, have you ever noticed color changes in your skin, such as red, white, or purple?

○ 1 **Yes** If Yes, complete the following box.

○ 2 **No** If No, go to question 65.

What color changes have occured? (Check all that apply.)

55. ○ **My skin turns red**

56. ○ **My skin turns white**

57. ○ **My skin turns purple**

58. ○ **Other, please Specify**____________________________

What parts of your body are affected by these color changes?
(Check all that apply.)

59. ○ **My hands**

60. ○ **My feet**

61. ○ **Other parts, please specify**____________________________

62. ○ **Entire body**

63. For how long have you been experiencing these changes in skin color?

○ 1 **Less than 3 months**

○ 2 **3 to 6 months**

○ 3 **7 to 12 months**

○ 4 **13 months to 5 years**

○ 5 **More than 5 years**

○ 6 **As long as I can remember**

64. Are these changes in your skin color:

○ 1 **Getting much worse**

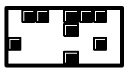
○ 2 **Getting somewhat worse**

○ 3 **Staying about the same**

○ 4 **Getting somewhat better**

○ 5 **Getting much better**

○ 6 **Completely gone**



65. In the past year, after a long hot bath or shower, have you ever noticed the pads on the ends of your fingers wrinkle up?

○ 1 Yes ○ 2 No

66. In the past 5 years, what changes, if any, have occurred in your general body sweating?

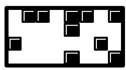
○ 1 I sweat much more than I used to
○ 2 I sweat somewhat more than I used to
○ 3 I haven't noticed any changes in my sweating
○ 4 I sweat somewhat less than I used to
○ 5 I sweat much less than I used to

67. In the past 5 years, what changes, if any, have occurred in the amount your feet sweat?

○ 1 They sweat much more than they used to
○ 2 They sweat somewhat more than they used to
○ 3 I haven't noticed any changes
○ 4 They sweat somewhat less than they used to
○ 5 They sweat much less than they used to

68. In the past 5 years, what changes, if any, have occurred in facial sweating after eating spicy foods?

○ 1 I sweat much more than I used to
○ 2 I sweat somewhat more than I used to
○ 3 I haven't noticed any changes in my sweating
○ 4 I sweat somewhat less than I used to
○ 5 I sweat much less than I used to
○ 6 I avoid eating spicy foods because I sweat so much
○ 7 I avoid eating spicy foods for other reasons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In the past 5 years, what changes, if any, have occurred in your ability to tolerate heat during a hot day, strenuous work or exercise, hot bath or shower, hot tub, or sauna?
(Check all that apply.)

69. ○ **I now get more overheated**

70. ○ **I now get dizzy**

71. ○ **I now get short of breath**

72. ○ **Other changes, please specify**________________________________

73. ○ **No change**

74. Do your eyes feel excessively dry?

○ 1 **Yes** ○ 2 **No**

75. Does your mouth feel excessively dry?

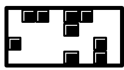
○ 1 **Yes** ○ 2 **No**

76. Do you have excessive amounts of saliva formation?

○ 1 **Yes** ○ 2 **No**

77. What is the longest period of time that you have had any one of these symptoms: dry eyes, dry mouth, or increased saliva production?

○ 0 **I have not had any of these symptoms**
○ 1 **Less than 3 months**
○ 2 **3 to 6 months**
○ 3 **7 to 12 months**
○ 4 **13 months to 5 years**
○ 5 **More than 5 years**
○ 6 **As long as I can remember**



78. For the symptom of dry eyes, dry mouth, or increased saliva production that you have had for the longest period of time, is this symptom:

- ○ 0 I have not had any of these symptoms
- ○ 1 Getting much worse
- ○ 2 Getting somewhat worse
- ○ 3 Staying about the same
- ○ 4 Getting somewhat better
- ○ 5 Getting much better
- ○ 6 Completely gone

79. What weight changes, if any, have you had over the past year?

- ○ 1 I have lost about________pounds
- ○ 2 My weight has not changed
- ○ 3 I have gained about________pounds

80. In the past year, have you noticed any changes in how quickly you get full when eating a meal?

- ○ 1 I get full a lot more quickly now than I used to
- ○ 2 I get full more quickly now than I used to
- ○ 3 I haven't noticed any change
- ○ 4 I get full less quickly now than I used to
- ○ 5 I get full a lot less quickly now than I used to

81. In the past year, have you felt excessively full or persistently full (bloated feeling) after a meal?

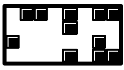
○ 1 Never ○ 2 Sometimes ○ 3 A lot of the time

82. In the past year, have you felt like you had a persistent upset stomach (nausea)?

○ 1 Never ○ 2 Sometimes ○ 3 A lot of the time

83. In the past year, have you vomited after a meal?

○ 1 Never ○ 2 Sometimes ○ 3 A lot of the time



84. In the past year, have you had a cramping or colicky abdominal pain?

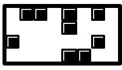
- ○ 1 **Never** — If Never, go to the next page.
- ○ 2 **Sometimes** — Else, complete the box below.
- ○ 3 **A lot of the time**

85. Are these pains usually after a meal?

○ 1 **Yes** ○ 2 **No**

86. How long have you had these cramping or colicky abdominal pains?

- ○ 1 **Less than 3 months**
- ○ 2 **3 to 6 months**
- ○ 3 **7 to 12 months**
- ○ 4 **13 months to 5 years**
- ○ 5 **More than 5 years**
- ○ 6 **As long as I can remember**



2178

87 **In the past year, have you had any bouts of diarrhea?**

- ○1 **Yes** If Yes, please complete the box below.
- ○2 **No** If No, go to the next page.

88 **How frequently does this occur?**

- ○1 **Rarely**
- ○2 **Occasionally**
- ○3 **Frequently, _____times per month**
- ○4 **Constantly**

89 **How severe are these bouts of diarrhea?**

○1 **Mild** ○2 **Moderate** ○3 **Severe**

90 **What part of the day do they seem to be worse?**

- ○1 **First thing in the morning**
- ○2 **Rest of the morning**
- ○3 **Afternoon**
- ○4 **Evening**
- ○5 **During the night**
- ○6 **No particular time**

91 **Do these bouts of diarrhea usually occur after a meal?**

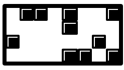
○1 **Yes** ○2 **No**

92 **Are these bouts of diarrhea accompanied by a lot of rectal gas (flatus)?**

○1 **Never** ○2 **Occasionally** ○3 **Frequently** ○4 **Always**

93 **Are your bouts with diarrhea getting:**

- ○1 **Much worse**
- ○2 **Somewhat worse**
- ○3 **Staying the same**
- ○4 **Somewhat better**
- ○5 **Much better**
- ○6 **Completely gone**



2178

94 **In the past year, have you been constipated?**

- ○ 1 **Yes** If Yes, complete the box below.
- ○ 2 **No** If No, go to the next page.

95 **How frequently are you constipated?**

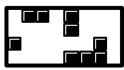
- ○ 1 **Rarely**
- ○ 2 **Occasionally**
- ○ 3 **Frequently, _____times per month**
- ○ 4 **Constantly**

96 **How severe are these episodes of constipation?**

○ 1 **Mild** ○ 2 **Moderate** ○ 3 **Severe**

97 **Is your constipation getting:**

- ○ 1 **Much worse**
- ○ 2 **Somewhat worse**
- ○ 3 **Staying the same**
- ○ 4 **Somewhat better**
- ○ 5 **Much better**
- ○ 6 **Completely gone**



2178

98 **Overall, are your abdominal symptoms of vomiting, diarrhea, constipation, or weight loss getting:**

- ○ 0 **I have not had these symptoms**
- ○ 1 **Much worse**
- ○ 2 **Somewhat worse**
- ○ 3 **Staying the same**
- ○ 4 **Somewhat better**
- ○ 5 **Much better**
- ○ 6 **Completely gone**

99 **Which one of the following symptoms have been most troublesome for you?** (Check only one.)

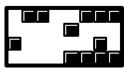
- ○ 0 **None**
- ○ 1 **Vomiting**
- ○ 2 **Diarrhea**
- ○ 3 **Constipation**
- ○ 4 **Weight loss**

100 **How long have you had this most troublesome symptom?**

- ○ 0 **I do not have any of these symptoms**
- ○ 1 **Less than 3 months**
- ○ 2 **3 to 6 months**
- ○ 3 **7 to 12 months**
- ○ 4 **13 months to 5 years**
- ○ 5 **More than 5 years**
- ○ 6 **As long as I can remember**

101 **Is this most troublesome symptom getting:**

- ○ 0 **I do not have any of these symptoms**
- ○ 1 **Much worse**
- ○ 2 **Somewhat worse**
- ○ 3 **Staying the same**
- ○ 4 **Somewhat better**
- ○ 5 **Much better**
- ○ 6 **Completely gone**



2178

102 **In the past 5 years, how would you rate the amount of trouble,if any, you have had with difficulty in swallowing?**

- ○ 1 **No trouble**
- ○ 2 **Some trouble**
- ○ 3 **A lot of trouble**
- ○ 4 **Constant trouble**

103 **In the past 5 years, how would you rate the amount of trouble,if any, you have had with everything you eat tasting the same?**

- ○ 1 **No trouble**
- ○ 2 **Some trouble**
- ○ 3 **A lot of trouble**
- ○ 4 **Constant trouble**

Have you ever in your adult life:

104 **been nauseated or vomited?**

○ 1 **Yes** ○ 2 **No**

105 **had a bout of diarrhea?**

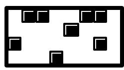
○ 1 **Yes** ○ 2 **No**

106 **lost your appetite for at least part of a day?**

○ 1 **Yes** ○ 2 **No**

107 **felt discomfort or pain in the pit of your stomach?**

○ 1 **Yes** ○ 2 **No**



2178

108 **In the past year, have you ever leaked urine or lost control of your bladder function?**

- ○ 1 **Never**
- ○ 2 **Occasionally**
- ○ 3 **Frequently, _____times per month**
- ○ 4 **Constantly**

109 **In the past year, have you had difficulty passing urine?**

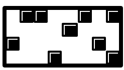
- ○ 1 **Never**
- ○ 2 **Occasionally**
- ○ 3 **Frequently, _____times per month**
- ○ 4 **Constantly**

110 **In the past year, have you had trouble completely emptying your bladder?**

- ○ 1 **Never**
- ○ 2 **Occasionally**
- ○ 3 **Frequently, _____times per month**
- ○ 4 **Constantly**

111 **How would you describe your current sexual desire?**

- ○ 1 **Completely absent**
- ○ 2 **Greatly reduced**
- ○ 3 **Somewhat reduced**
- ○ 4 **About the same or more than in the past**



If Male, Please Complete This Box.

112 **Are you able to have a full erection?**

- ○ 1 **Never, under any circumstances**
- ○ 2 **Much less frequently than in past**
- ○ 3 **Somewhat less frequently than in past**
- ○ 4 **The same, or more frequently, than in past**

Which of the following statements apply to your situation?
(Fill in all that apply.)

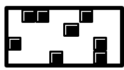
- 113 ○ 1 **My ability to have intercourse has not changed**
- 114 ○ 1 **I have erections but am unable to have intercourse**
- 115 ○ 1 **I can have intercourse only some of the time**
- 116 ○ 1 **My erections are definitely impaired**
- 117 ○ 1 **I am able to have intercourse, but am unable to ejaculate**
- 118 ○ 1 **I have "dry orgasms" and afterward my urine looks milky**
- 119 ○ 1 **I have been unable to have erections or they have been impaired since I started taking a medication called ________________________**
- 120 ○ 1 **Other situation, please describe________________________**
- 121 ○ 1 **None of the above apply**

122 **How long have you had difficulty with erectile function?**

- ○ 0 **I do not have this difficulty**
- ○ 1 **Less than 3 months**
- ○ 2 **3 to 6 months**
- ○ 3 **7 to 12 months**
- ○ 4 **13 months to 5 years**
- ○ 5 **More than 5 years**
- ○ 6 **As long as I can remember**

123 **Is this difficulty getting:**

- ○ 0 **I have not had difficulty**
- ○ 1 **Much worse**
- ○ 2 **Somewhat worse**
- ○ 3 **Staying the same**
- ○ 4 **Somewhat better**
- ○ 5 **Much better**
- ○ 6 **Completely gone**



2178

124 **In the past year, without sunglasses or tinted glasses, has bright light bothered your eyes?**

○ 1 Never ○ 2 Occasionally ○ 3 Frequently ○ 4 Constantly

125 **How severe is this sensitivity to bright light?**

○ 1 Mild ○ 2 Moderate ○ 3 Severe

126 **In the past year, have you had trouble focusing your eyes?**

○ 1 Never ○ 2 Occasionally ○ 3 Frequently ○ 4 Constantly

127 **How severe is this focusing problem?**

○ 1 Mild ○ 2 Moderate ○ 3 Severe

128 **In the past year, have you had blurred vision?**

○ 1 Never ○ 2 Occasionally ○ 3 Frequently ○ 4 Constantly

129 **How severe is this blurred vision?**

○ 1 Mild ○ 2 Moderate ○ 3 Severe

130 **In the past year, have you had difficulty seeing at night?**

○ 1 Never ○ 2 Occasionally ○ 3 Frequently ○ 4 Constantly

131 **How severe is this night vision problem?**

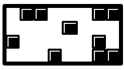
○ 1 Mild ○ 2 Moderate ○ 3 Severe

132 **In the past year, has the same degree of light seemed:**

○ 1 Excessively dimmer ○ 2 Much dimmer ○ 3 About the same ○ 4 Much brighter ○ 5 Excessively brighter

133 **Which one of the following eye symptoms is the most troublesome for You?** (Check only one)

○ 0 None ○ 1 Trouble Focusing ○ 2 Blurred Vision ○ 3 Difficulty seeing at night

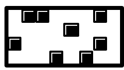


134 **How long have your had this most troublesome eye symptom?**

- ○ 0 I don't have any of these symptoms
- ○ 1 Less than 3 months
- ○ 2 3 to 6 months
- ○ 3 7 to 12 months
- ○ 4 13 months to 5 years
- ○ 5 More than 5 years
- ○ 6 As long as I can remember

135 **Is this most troublesome symptom with your eyes getting:**

- ○ 0 I don't have any of these symptoms
- ○ 1 Much worse
- ○ 2 Somewhat worse
- ○ 3 Staying the same
- ○ 4 Somewhat better
- ○ 5 Much better
- ○ 6 Completely gone



136 **In the past year, have you ever noticed or been told that while sleeping you stop breathing for several seconds?**

○ 1 Yes ○ 2 No

137 **In the past year, have you ever noticed or been told that while sleeping you snore loudly?**

○ 1 Yes ○ 2 No

Have you ever been told you have or been diagnosed as having:

138	**Narcolepsy?**	○ 1 Yes	○ 2 No	○ 3 Don't know
139	**Obstructive sleep apnea?**	○ 1 Yes	○ 2 No	○ 3 Don't know
140	**Abnormal or disordered sleep patterns?**	○ 1 Yes	○ 2 No	○ 3 Don't know

141 **Currently, how refreshing and restorative is your sleep?**

○ 1 Not at all restorative - derive no benefit
○ 2 Some slight restorative value
○ 3 Restorative, but not adequate
○ 4 Relatively satisfactory
○ 5 Very satisfactory - feel completely refreshed

142 **Compared with a year ago, how would you rate your own sleep over the last month?**

○ 1 Last month was much worse than a year ago
○ 2 Last month was slightly worse than a year ago
○ 3 Last month was about the same as a year ago
○ 4 Last month was slightly better than a year ago
○ 5 Last month was much better than a year ago

143 **Have you ever in your adult life had difficulty getting to sleep or staying asleep once you were asleep?**

○ 1 Yes ○ 2 No

144 **In the past year, have you ever noticed or been told that during the day you sometimes breathe very loudly(e.g.,croup)?**

○ 1 Yes ○ 2 No

How would you describe your alcohol use over the past year?
(Check all that apply.)

145 ○ 1 **I have not drank any alcohol over the past year**
146 ○ 1 **I drink socially only**
147 ○ 1 **I have used alcohol excessively in the past year**
148 ○ 1 **I have been intoxicated one or more times in the past year**
149 ○ 1 **I have passed out from drinking too much alcohol one or more times in the past year**

How would you describe your drug use over the past year?
(Check all that apply.)

150 ○ 1 **I have not used drugs over the past year**
151 ○ 1 **I have used drugs excessively in the past year**
152 ○ 1 **I have been intoxicated one or more times in the past year**
153 ○ 1 **I have passed out from drinking too much alcohol one or more times in the past year**

154 **Have you ever felt that you have used alcohol or drugs excessively?**

○ 1 **Yes** ○ 2 **No**

155 **Have you ever been told or have you been diagnosed as having alcohol or drug dependency?**

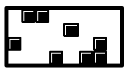
○ 1 **Yes** ○ 2 **No**

156 **Have you ever received treatment for alcohol or other drug dependency?**

○ 1 **Yes**
○ 2 **No**

Please list the drugs involved, including alcohol

1. ________________________
2. ________________________
3. ________________________
4. ________________________



2178

Which of the following describe your cigarette smoking?
(Check all that apply.)

157 ○ **I have never smoked cigarettes**

158 ○ **I have smoked cigarettes in the past but have stopped:**

Date Quit:

159 _______________

163 ○ **I am currently smoking about**

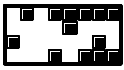
164 _____ **cigarettes per day**

166 **In the past 5 years, how would you rate the amount of trouble, if any, you have had with oversensitive hearing?**

○ **1 None** ○ **2 Some** ○ **3 A lot** ○ **4 Constant**

167 **Have you ever in your adult life had difficulty keeping your mind on your job or task?**

○ **1 Yes** ○ **2 No**



2178

What medications have you taken in the past month?

Name of medicine	How often do you take it?	How much do you take each time?

We welcome below any comments you might have about what might have caused or been associated with your current illness or anything that might be helpful to us in understanding your current condition.

COMPASS

Answer every question by darkening the appropriate oval (○). If you are unsure about how to answer a question, please give the best answer you can.

Marking Instructions

Use a NO. 2 pencil.
Darken the corresponding oval completely.
Fill in the number in the box, if provided.
Erase completely any marks you wish to change.

ID ____

Today's Date (01/02/2007) _ _ / _ _ / _ _ _ _

Diagnosis______________________________________

1. In the past year, have you ever felt faint, dizzy, or "goofy" or had difficulty thinking soon after standing up from a sitting or lying down position?

- O **Yes** *If you marked YES go to question 19.*
- O **No** *If you marked No go to question 37.*

2. When standing up, how frequently do you get these feelings or symptoms?

- O **Rarely**
- O **Occasionally**
- O **Frequently**
- O **Almost always**

3. How would you rate the severity of these feelings or symptoms?

- O **Mild**
- O **Moderate**
- O **Severe**

4. For how long have you been experiencing these feelings or symptoms?

- O **Less than 3 months**
- O **3 to 6 months**
- O **7 to 12 months**
- O **13 months to 5 years**
- O **More than 5 years**
- O **As long as I can remember**

5. In the past year, how often have you ended up fainting soon after standing up from a sitting or lying down position?

- O **Never**
- O **Once**
- O **Twice**
- O **Three times**
- O **Four times**
- O **Five or more times**

6. How cautious are you about standing up from a sitting or lying down position?

- O **Not cautious at all**
- O **Somewhat cautious**
- O **Extremely cautious**

7. What part of the day are these feelings worse?
(Check only one)

- O **Early morning**
- O **Rest of morning**
- O **Afternoon**
- O **Evening**
- O **At night, when I get up after I've been asleep**
- O **No particular time is worse**
- O **Other time, specify____**

8. In the past year, have these feelings or symptoms that you Have experienced:

- O **Gotten much worse**
- O **Gotten somewhat worse**
- O **Stayed about the same**
- O **Gotten somewhat better**
- O **Gotten much better**
- O **Completely gone**

Please rate the average severity you have experienced in the past year for each of the following symptoms.

	Have not had	Mild	Moderate	Severe
9. Rapid or increased heart rate?(palpitations)	O	O	O	O
10. Sickness to your stomach(nausea) or vomiting?	O	O	O	O
11. A spinning or swimming sensation?	O	O	O	O
12. Dizziness?	O	O	O	O
13. Blurred vision?	O	O	O	O
14. Feeling of Weakness?	O	O	O	O
15. Feeling shaky or shaking sensation?	O	O	O	O
16. Feeling anxious or nervous?	O	O	O	O
17. Turning pale?	O	O	O	O
18. Clammy feeling to your skin?	O	O	O	O

19. Do you have any biologic (blood,natural) relatives amoung your parents, grandparents, brothers, sisters, or children who have frequent dizziness after standing from a sitting or lying down position?

O **Yes**
O **No**

If Yes, please list their names and relationship to you.

Name	**Relationship**
________________________	______________________
________________________	______________________
________________________	______________________
________________________	______________________

In the past year, have you ever felt faint, dizzy, or "goofy" or had difficulty thinking:

20. soon after a meal?_________________________ O **Yes** O **No**

21. after standing for a long time?___________ O **Yes** O **No**

22. during or soon after physical activity___ O **Yes** O **No**
or exercise?

23. during or soon after being in a hotbath,_ O **Yes** O **No**
shower, tub, or sauna?

24. Have you ever felt dizzy or faint or actually fainted when you saw blood or had a bloodsample taken?

O **Yes** O **No**

In the past year, have you fainted:

25. While passing urine?_________________________ O **Yes** O **No**

26. While coughing?______________________________ O **Yes** O **No**

27. While pressing on side of neck?____________ O **Yes** O **No**

28. Before a public speech?____________________ O **Yes** O **No**

29. Any other time?______________________________ O **Yes** O **No**

If you checked "Yes" to any of these questions on fainting, please describe circumstances below

____

30. In the past year, have you ever completely lost consciousness after a spell of dizziness?

O **Yes** O **No**

31. In the past year, have you had any seizures or convulsions?

O **Yes** *If you checked "Yes" p*lease describe circumstances
O **No** below

____

In the past 5 years how would rate the amount of trouble, if any, you have had:

	None	Some	A Lot	Constant
32. with paralysis in parts of your face?	O	O	O	O
33. with feelings of complete weakness all over your body?	O	O	O	O
34. with attacks of uncontrollable movements of your arms or legs?	O	O	O	O
35. with attacks in which you couldn't Control your speech?	O	O	O	O

36. Have you ever in your adult life had a spell of dizziness?

O **Yes** O **No**

37. In the past year, have you ever noticed color changes in your skin, such as red, white, or purple?

O **Yes** If Yes, complete the following box.
O **NO** If No, go to question 65.

What color changes have occured? *(Check all that apply.)*

38. O **My skin turns red**

39. O **My skin turns white**

40. O **My skin turns purple**

41. O **Other, please specify**_______________________________

What parts of your body are affected by these color changes? (*Check all that apply.*)

42. O **My hands**

43. O **My feet**

44. O **Other parts, please specify**__________________________

45. O **Entire body**

46. For how long have you been experiencing these changes in skin color?

O **Less than 3 months**
O **3 to 6 months**
O **7 to 12 months**
O **13 months to 5 years**
O **More than 5 years**
O **As long as I can remember**

47. Are these changes in your skin color:

O **Getting much worse**
O **Getting somewhat worse**
O **Staying about the same**
O **Getting somewhat better**
O **Getting much better**
O **Completely gone**

48. In the past year, after a long hot bath or shower, have you ever noticed the pads on the ends of your fingers wrinkle up?

O **Yes** O **No**

49. In the past 5 years, what changes, if any, have occurred in your general body sweating?

O **I sweat much more than I used to**
O **I sweat somewhat more than I used to**
O **I haven't noticed any changes in my sweating**
O **I sweat somewhat less than I used to**
O **I sweat much less than I used to**

50. In the past 5 years, what changes, if any, have occurred in the amount your feet sweat?

O **They sweat much more than they used to**
O **They sweat somewhat more than they used to**
O **I haven't noticed any changes**
O **They sweat somewhat less than they used to**
O **They sweat much less than they used to**

51. In the past 5 years, what changes, if any, have occurred in facial sweating after eating spicy foods?

O **I sweat much more than I used to**
O **I sweat somewhat more than I used to**
O **I haven't noticed any changes in my sweating**
O **I sweat somewhat less than I used to**
O **I sweat much less than I used to**
O **I avoid eating spicy foods because I sweat so much**
O **I avoid eating spicy foods for other reasons**

In the past 5 years, what changes, if any, have occurred in your ability to tolerate heat during a hot day, strenuous work or exercise, hot bath or shower, hot tub, or sauna?
(Check all that apply.)

52. O **I now get more overheated**

53. O **I now get dizzy**

54. O **I now get short of breath**

55. O **Other changes, please specify______________________________**

56. O **No change**

57. Do your eyes feel excessively dry?

O **Yes** O **No**

58. Does your mouth feel excessively dry?

O **Yes** O **No**

59. Do you have excessive amounts of saliva formation?

O **Yes** O **No**

60. What is the longest period of time that you have had any one of these symptoms: dry eyes, dry mouth, or increased saliva production?

O **I have not had any of these symptoms**
O **Less than 3 months**
O **3 to 6 months**
O **7 to 12 months**
O **13 months to 5 years**
O **More than 5 years**
O **As long as I can remember**

61. For the symptom of dry eyes, dry mouth, or increased saliva production that you have had for the longest period of time, is this symptom:

- O I have not had any of these symptoms
- O Getting much worse
- O 2 Getting somewhat worse
- O Staying about the same
- O Getting somewhat better
- O Getting much better
- O Completely gone

62. What weight changes, if any, have you had over the past year?

- O I have lost about________pounds
- O My weight has not changed
- O I have gained about________pounds

63. In the past year, have you noticed any changes in how quickly you get full when eating a meal?

- O I get full a lot more quickly now than I used to
- O I get full more quickly now than I used to
- O I haven't noticed any change
- O I get full less quickly now than I used to
- O I get full a lot less quicklly now than I used to

64. In the past year, have you felt excessively full or persistently full (bloated feeling) after a meal?

- O Never
- O Sometimes
- O A lot of the time

65. In the past year, have you felt like you had a persistent upset stomach (nausea)?

- O Never
- O Sometimes
- O A lot of the time

66. In the past year, have you vomited after a meal?

- O Never
- O Sometimes
- O A lot of the time

67. In the past year, have you had a cramping or colicky abdominal pain?

- O **Never** *If never, go to the next page.*
- O **Sometimes** *Else complete the box below.*
- O **A lot of the time**

68. Are these pains usually after a meal?

- O **Yes**
- O **No**

69. How long have you had these cramping or colicky abdominal pains?

- O **Less than 3 months**
- O **3 to 6 months**
- O **7 to 12 months**
- O **13 months to 5 years**
- O **More than 5 years**
- O **As long as I can remember**

70. In the past year, have you had any bouts of diarrhea?

O **Yes** *If Yes, please complete the box below.*
O **No** *If No, go to the next page.*

71. How frequently does this occur?

O **Rarely**
O **Occasionally**
O **Frequently, _____times per month**
O **Constantly**

72. How severe are these bouts of diarrhea?
O **Mild**
O **Moderate**
O **Severe**

73. What part of the day do they seem to be worse?

O **First thing in the morning**
O **Rest of the morning**
O **Afternoon**
O **Evening**
O **During the night**
O **No particular time**

74. Do these bouts of diarrhea usually occur after meal?

O **Yes**
O **No**

75. Are these bouts of diarrhea accompanied with lots of rectal gas (flatus)?

O **Never**
O **Occasionally**
O **Frequently**
O **Always**

76. Are your bouts with diarrhea getting:

O **Much worse**
O **Somewhat worse**
O **Staying the same**
O **Somewhat better**
O **Much better**
O **Completely gone**

77. In the past year, have you been constipated?

O **Yes** *If Yes, please complete the box below.*
O **No** *If No, go to the next page.*

78. How Frequently are you constipated?

O **Rarely**
O **Occasionally**
O **Frequently, _____times per month**
O **Constantly**

79. How severe are these episodes of constipation?

O **Mild**
O **Moderate**
O **Severe**

80. Is your constipation getting:

O **Much worse**
O **Somewhat worse**
O **Staying the same**
O **Somewhat better**
O **Much better**
O **Completely gone**

81. Overall, are your abdominal symptoms of vomiting, diarrhea, constipation, or weight loss getting:

- O **I have not had these symptoms**
- O **Much worse**
- O **Somewhat worse**
- O **Staying the same**
- O **Somewhat better**
- O **Much better**
- O **Completely gone**

82. Which one of the following symptoms have been most troublesome for you? *(Check only one.)*

- O **None**
- O **Vomiting**
- O **Diarrhea**
- O **Constipation**
- O **Weight loss**

83. How long have you had this most troublesome symptom?

- O **I do not have any of these symptoms**
- O **Less than 3 months**
- O **3 to 6 months**
- O **7 to 12 months**
- O **13 months to 5 years**
- O **More than 5 years**
- O **As long as I can remember**

84. Is this most troublesome symptom getting:

- O **I do not have any of these symptoms**
- O **Much worse**
- O **Somewhat worse**
- O **Staying the same**
- O **Somewhat better**
- O **Much better**
- O **Completely gone**

85. In the past 5 years, how would you rate the amount of trouble, if any, you have had with difficulty in swallowing?

- O **No trouble**
- O **Some trouble**
- O **A lot of trouble**
- O **Constant trouble**

86. In the past 5 years, how would you rate the amount of trouble, if any, you have had with everything you eat tasting the same?

- O **No trouble**
- O **Some trouble**
- O **A lot of trouble**
- O **Constant trouble**

Have you ever in your adult life:

87. been nauseated or vomited?

- O **Yes**
- O **No**

88. had a bout of diarrhea?

- O **Yes**
- O **No**

89. lost your appetite for at least part of a day?

- O **Yes**
- O **No**

90. felt discomfort or pain in the pit of your stomach?

- O **Yes**
- O **No**

91. In the past year, have you ever leaked urine or lost control of your bladder function?

- O **Never**
- O **Occasionally**
- O **Frequently, _____times per month**
- O **Constantly**

92. In the past year, have had difficulty passing urine?

- O **Never**
- O **Occasionally**
- O **Frequently, _____times per month**
- O **Constantly**

93. In the past year, have you had trouble completely emptying your bladder?

- O **Never**
- O **Occasionally**
- O **Frequently, _____times per month**
- O **Constantly**

94. How would you describe your current sexual desire?

- O **Completely absent**
- O **Greatly reduced**
- O **Somewhat reduced**
- O **About the same or more than in the past**

If male, please complete this box.

95. Are you able to have a full erection?

- O **Never, under any circumstances**
- O **Much less frequently than in past**
- O **Somewhat less frequently than in past**
- O **The same, or more frequently, than in past**

Which of the following statements apply to your situation?
(Fill in all that apply.)

96. O **My ability to have intercourse has not changed**
97. O **I have erections but am unable to have intercourse**
98. O **I can have intercourse only some of the time**
99. O **My erections are definitely impaired**
100. O **I am able to have intercourse, but am unable to ejaculate**
101. O **I have "dry orgasms" and afterward my urine looks milky**
102. O **I have been unable to have erections or they have been impaired since I started taking a medication called _________________________**
103. O **Other situation, please describe__________________________**
104. O **None of the above apply**

105. How long have you had difficulty with erectile function?

- O **I do not have this difficulty**
- O **Less than 3 months**
- O **3 to 6 months**
- O **7 to 12 months**
- O **13 months to 5 years**
- O **More than 5 years**
- O **As long as I can remember**

106. Is this difficulty getting:

- O **I have not had difficulty**
- O **Much worse**
- O **Somewhat worse**
- O **Staying the same**
- O **Somewhat better**
- O **Much better**
- O **Completely gone**

107. In the past year, without sunglasses or tinted glasses, has bright light bothered your eyes?

O Never O Occasionally O Frequently O Constantly

108. How severe is this sensitivity to bright light?
O Mild O Moderate O Severe

109. In the past year, have you had trouble focusing your eyes?

O Never O Occasionally O Frequently O Constantly

110. How severe is this focusing problem?
O Mild O Moderate O Severe

111. In the past year, have you had blurred vision?

O Never O Occasionally O Frequently O Constantly

112. How severe is this blurred vision problem?
O Mild O Moderate O Severe

113. In the past year, have you had difficulty seeing at night?

O Never O Occasionally O Frequently O Constantly

114. How severe is this difficulty seeing at night?
O Mild O Moderate O Severe

115. In the past year, has the same degree of light seemed:

O Excessively dimmer
O Much dimmer
O About the same
O Much brighter
O Excessively brighter

116. Which one of the following eye symptoms is the most troublesome for You?

O None
O Trouble Focusing
O Blurred Vision
O Difficulty seeing at night

117. How long have your had this most troublesome eye symptom?

O **I don't have any of these symptoms**
O **Less than 3 months**
O **3 to 6 months**
O **7 to 12 months**
O **13 months to 5 years**
O **More than 5 years**
O **As long as I can remember**

118. Is this most troublesome symptom with your eyes getting:

O **I don't have any of these symptoms**
O **Much worse**
O **Somewhat worse**
O **Staying the same**
O **Somewhat better**
O **Much better**
O **Completely gone**

119. In the past year, have you ever noticed or been told that while sleeping you stop breathing for several seconds?

O **Yes** O **No**

120. In the past year, have you ever noticed or been told that while sleeping you snore loudly?

O **Yes** O **No**

Have you ever been told you have or been diagnosed as having:

121. Narcolepsy?	O **Yes**	O **No**	O **Don't know**
122. Obstructive sleep apnea?	O **Yes**	O **No**	O **Don't know**
123. Abnormal or disordered sleep pattens?	O **Yes**	O **No**	O **Don't know**

124. Currently, how refreshing and restorative is your sleep?

O **Not at all restorative - derive no benefit**
O **Some slight restorative value**
O **Restorative, but not adequate**
O **Relatively satisfactory**
O **Very satisfactory - feel completely refreshed**

125. Compared with a year ago, how would you rate your own sleep over the last month?

O **Last month was much worse than a year ago**
O **Last month was slightly worse than a year ago**
O **Last month was about the same as a year ago**
O **Last month was slightly better than a year ago**
O **Last month was much better than a year ago**

126. Have you ever in your adult life had difficulty getting to sleep or staying asleep once you were asleep?

O **Yes**
O **No**

127. In the past year, have you ever noticed or been told that during the day you sometimes breathe very loudly(e.g.,croup)?

O **Yes**
O **No**

How would you describe your alcohol use over the past year?
(Check all that apply.)

128. O **I have not drank any alcohol over the past year**

129. O **I drink socially only**

130. O **I have used alcohol excessively in the past year**

131. O **I have been intoxicated one or more times in the past year**

132. O **I have passed out from drinking too much alcohol one or more times in the past year**

How would you describe your drug use over the past year?
(Check all that apply.)

133. O **I have not used drugs over the past year**

134. O **I have used drugs excessively in the past year**

135. O **I have been high one or more times in the past year**

136. O **I have passed out from using drugs one or more times in the past year**

137. Have you ever felt that you have used alcohol or drugs excessively?

O **Yes**
O **No**

138. Have you ever been told you have or been diagnosed as having alcohol or drug dependency?

O **Yes**
O **No**

139. Have you ever received treatment for alcohol or other drug dependency?

O **Yes** *If yes, Please list the drugs* **1.**______________________
O **No** *involved, including alcohol* **2.**______________________
3.______________________
4.______________________

Which of the following describe your cigarette smoking?
(Check all that apply.)

140. O **I have never smoked cigarettes**

141. O **I have smoked cigarettes in the past but have stopped:**

Date Quit
142. __________

143. O **I am currently smoking about**

144. _____ **cigarettes per day**

145. In the past 5 years, how would you rate the amount of trouble, if any, you have had with over sensitive hearing?

O **None**
O **Some**
O **A lot**
O **Constant**

146. Have you ever in your adult life had difficulty keeping your mind on your job or task?

O **Yes**
O **No**