Healthy Subject's Research Candidate Questionnaire – *Complete in Dark Ink*

Please note that all answers will be kept confidential. You can complete this form on your computer. When you are done, print it out and FAX it to 212-844-6724.

Today's date: _____

Name: _____ Home phone: _____

Address: _____ Work phone: _____

_____ Mobile phone: _____

E-mail _____ Date of birth _____

What is your… Height? _____ Weight? _____ Age? _____ Sex? _____

What is your culture? ◯ Hispanic ◯ Non-Hispanic

What is your race?

◯ White
◯ Black/African American
◯ Asian
◯ American Indian or Native Alaskan
◯ Native Hawaiian or other Pacific Islander
◯ Other, mixed, or unknown

Employment status (choose one)

◯ Full Time
◯ Part Time
◯ Unemployed, looking for work
◯ Unemployed due to health
◯ Retired (for any reason)
◯ Never worked outside home
◯ Other, please specify _____

Marital Status (choose one)

◯ Married
◯ Divorced
◯ Never Married
◯ Widowed
◯ Separated
◯ Living as Married

1. Have you had any illness, other than colds or the flu, in the past five years? ◯ Yes ◯ No

   If yes, please indicate the name of the illness, how long the illness lasted, and whether you currently have any symptoms:

   _____

   _____

2. Please rate your health: ◯ Excellent ◯ Good ◯ Fair ◯ Poor

   If not excellent, please explain: _____

3. Are you currently taking any proscription medication, other than birth control pills?
   ◯ Yes ◯ No

   If yes, please provide medication names and dosages:

   _____

   _____

4. Have you ever had trauma or injury to your head which resulted in loss of consciousness?
◯ Yes ◯ No

If yes, how long were you unconscious? _____
Minutes? Hours? Days?

Did you lose memory for events immediately before the accident? ◯ Yes ◯ No
If yes, for how long before the event? _____

Did you lose memory for events immediately after the accident? ◯ Yes ◯ No
If yes, for how long after the event? _____

At the time of the trauma or head injury did you feel dazed? ◯ Yes ◯ No
disoriented? ◯ Yes ◯ No
confused? ◯ Yes ◯ No

5. **Over the last 3 months**, have you had pain in your muscles, bones or joints lasting at least 1 week?
◯ Yes ◯ No

6. Please rate how the following list of products or situations affects your health. In these statements, sick means that you get a headache, an upset stomach, dizziness, or something similar. If you don't know how these products or situations make you feel, then indicate that on the scale.

	No problem	Bothers me	A little sick	Very sick	Don't know	Not applicable
Cologne, aftershave or perfume.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6
Walking down the detergent aisle at the grocery store.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6
Going into a beauty salon or barber shop.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6
Walking into a room with brand new carpets.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6
Reading freshly printed newspaper.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6
Sitting in a room where someone else is smoking.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6
Using ammonia or chlorine bleach around the house.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6
Using bug spray in the house.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6
Waiting for the traffic light to turn green and smelling the car and bus exhaust.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6
Using a bathroom with a scented air freshener.	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6

7. Have you ever had a fatiguing illness, such as mono, which lasted more than two weeks? ◯ Yes ◯ No

If yes, what caused the fatigue and how long did it last?

_____

_____

8. How often do you exercise per week and what type of exercise do you do each time?

_____

_____

8a. If you do exercise, for what duration and at what intensity (light, medium, hard) on each of your exercise days?

_____

_____

9. Rate the degree to which you have had the following symptoms ***IN THE PAST MONTH?***
(0 = Never a problem, 1= a mild problem, 2 = a moderate problem, 3 = a substantial problem, 4 = a severe problem and 5 = a very severe problem)

	In the past month (choose one)					
Fatigue, tiredness, or exhaustion not caused by not enough sleep	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5
Feeling feverish	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5
Sore throat	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5
Tender glands (lumps felt by you or your doctor)	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5
Headaches	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5
Muscle discomfort or pains	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5
Unexplained weakness in many muscles	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5
Pain in more than one joint without redness or swelling	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5
Prolonged fatigue or a feeling of illness after mild exercise	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5
Unrefreshing sleep	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5
Difficulty with attention or concentration	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5
Bowel trouble (constipation and diarrhea)	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5
Shortness of breath or difficulty breathing	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5
Stomach or digestive troubles	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5
Skin rashes	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5
Inability to hold urine	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5
Dizzy spells	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5
Chest pain	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5
Cough	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5
Shakiness	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5

10. What is the best way to reach you?

◯ Phone

◯ Home _____
time & day

◯ Work _____
time & day

◯ Mobile _____
time & day