

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. Any questions? Please call 212-844-6665.

Name: _____ Today's date: _____
Address: _____ Home phone: _____
_____ 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.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6
Walking down the detergent aisle at the grocery store.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6
Going into a beauty salon or barber shop.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6
Walking into a room with brand new carpets.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6
Reading freshly printed newspaper.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6
Sitting in a room where someone else is smoking.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6
Using ammonia or chlorine bleach around the house.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6
Using bug spray in the house.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6
Waiting for the traffic light to turn green and smelling the car and bus exhaust.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6
Using a bathroom with a scented air freshener.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 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?

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	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Feeling feverish.....	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Sore throat.....	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Tender glands (lumps felt by you or your doctor).....	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Headaches.....	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Muscle discomfort or pains.....	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Unexplained weakness in many muscles.....	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Pain in more than one joint without redness or swelling.....	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Prolonged fatigue or a feeling of illness after mild exercise.....	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Unrefreshing sleep.....	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Difficulty with attention or concentration.....	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Bowel trouble (constipation and diarrhea).....	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Shortness of breath or difficulty breathing.....	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Stomach or digestive troubles.....	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Skin rashes.....	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Inability to hold urine.....	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Dizzy spells.....	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Chest pain.....	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Cough.....	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Shakiness.....	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5

10. What is the best way to reach you?

<input type="radio"/> Phone	<input type="radio"/> Home	_____
		<i>time & day</i>
	<input type="radio"/> Work	_____
		<i>time & day</i>
	<input type="radio"/> Mobile	_____
		<i>time & day</i>