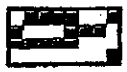

36600

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	OO	OOO	OOO
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Today's Date

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Diagnosis

_____

[redacted] [redacted]

36600

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

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

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

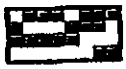
O 1 Rarely
O 2 Occasionallly
O 3 Frequently
O 4 Almost always

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

O 1 Mild
O 2 Moderate
O 3 Severe

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

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



36600

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 worst? (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 worst
- ○ 7 Other time, please specify_____

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

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

36600

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)	10	20	30	40
27. Sickness to your stomach(nausea) or vomiting?	10	20	30	40
28. A spinning or swimming sensation?	10	20	30	40
29. Dizziness?	10	20	30	40
30. Blurred vision?	10	20	30	40
31. Feeling of Weakness?	10	20	30	40
32. Feeling shaky or shaking sensation?	10	20	30	40
33. Feeling anxious or nervous?	10	20	30	40
34. Turning pale?	10	20	30	40
35. Clammy feeling to your skin?	10	20	30	40

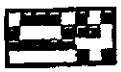
36. Do you have any biologic (blood,natural) relatives amoung your parents, grandparents, brothers, sisters, or children who have frequent dizziness after standing from a sitting or lying down position?

○1 Yes

○2 No

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

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____



36600

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

37. soon after a meal? ____ O 1 Yes O 2 No

38. after standing for a long time? ____ O 1 Yes O 2 No

39. during or soon after physical activity or exercise? ____ O 1 Yes O 2 No

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

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

O 1 Yes O 2 No

In the past year, have you fainted:

42. while passing urine? ____ O 1 Yes O 2 No

43. while coughing? ____ O 1 Yes O 2 No

44. while pressing on side of neck? ____ O 1 Yes O 2 No

45. before a public speech? ____ O 1 Yes O 2 No

46. any other time? ____ O 1 Yes O 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?

O 1 Yes O 2 No

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

O 1 Yes please describe

O 2 No circumstances

[redacted] [redacted]

36600

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

	None	Some	A lot	Constant
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

[redacted] [redacted] [redacted]

36600

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

O 1 Yes If Yes, complete the following box.

O 2 No If No, go to question 65.

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

55. O My skin turns red

56. O My skin turns white

57. O My skin turns purple

58. O Other, please Specify_____

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

59. O My hands

60. O My feet

61. O Other parts, please specify_____

62. O Entire body

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

O 1 Less than 3 months

O 2 3 to 6 months

O 3 7 to 12 months

O 4 13 months to 5 years

O 5 More than 5 years

O 6 As long as I can remember

64. Are these changes in your skin color:

O 1 Getting much worst

O 2 Getting somewhat worst

O 3 Staying about the same

O 4 Getting somewhat better

O 5 Getting much better

O 6 Completely gone

[redacted] [redacted]

36600

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?

O1 Yes O2 No

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

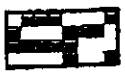
O1 I sweat much more than I used to
O2 I sweat somewhat more than I used to
O3 I haven't noticed any changes in my sweating
O4 I sweat somewhat less than I used to
O5 I sweat much less than I used to

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

O1 They sweat much more than they used to
O2 They sweat somewhat more than they used to
O3 I haven't noticed any changes
O4 They sweat somewhat less than they used to
O5 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?

O1 I sweat much more than I used to
O2 I sweat somewhat more than I used to
O3 I haven't noticed any changes in my sweating
O4 I sweat somewhat less than I used to
O5 I sweat much less than I used to
O6 I avoid eating spicy foods because I sweat so much
O7 I avoid eating spicy foods for other reasons



36600

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. O I now get more overheated

70. O I now get dizzy

71. O I now get short of breath

72. O Other changes, please specify_____

73. O No change

74. Do your eyes feel excessively dry?

O 1 Yes O 2 No

75. Does your mouth feel excessively dry?

O 1 Yes O 2 No

76. Do you have excessive amounts of saliva formation?

O 1 Yes O 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?

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

36600

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

[redacted] [redacted]

36600

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

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

85. Are these pains usually after a meal?

O 1 Yes O 2 No

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

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

36600

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

O 1 Yes (If Yes, please complete the box.)
O 2 No

88 How frequently does this occur?

O 1 Rarely
O 2 Occasionally
O 3 Frequently, _____times per month
O 4 Constantly

89 How severe are these bouts of diarrhea?

O 1 Mild O 2 Moderate O 3 Severe

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

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

91 Do these bouts of diarrhea usually occur after meal?

O 1 Yes O 2 No

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

O 1 Never O 2 Occasionally O 3 Frequently O 4 Always

93 Are your bouts with diarrhea:

O 1 Much worse
O 2 Somewhat worse
O 3 Staying the same
O 4 Somewhat better
O 5 Much better
O 6 Completely gone

[redacted] [redacted] [redacted]

36600

94 In the past year, have you been constipated?

O 1 Yes (If Yes, please complete the box.)

O 2 No

95 How frequently are you constipated?

O 1 Rarely

O 2 Occasionally

O 3 Frequently, _____times per month

O 4 Constantly

96 How severe are these episodes of constipation?

O 1 Mild O 2 Moderate O 3 Severe

97 Is your constipation getting:

O 1 Much worse

O 2 Somewhat worse

O 3 Staying the same

O 4 Somewhat better

O 5 Much better

O 6 Completely gone

[redacted] [redacted]

36600

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

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

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

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

100 How long have you had this most troublesome symptom?

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

101 Is this most troublesome symptom getting:

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

[redacted] [redacted]

[redacted] [redacted]

36600

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

- O 1 No trouble
- O 2 Some trouble
- O 3 A lot of trouble
- O 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?

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

Have you ever in your adult life:

104 been nauseated or vomited?

O 1 Yes O 2 No

105 had a bout of diarrhea?

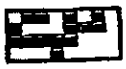
O 1 Yes O 2 No

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

O 1 Yes O 2 No

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

O 1 Yes O 2 No



36600

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

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

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

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

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

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

111 How would you describe your current sexual desire?

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

[redacted] [redacted]

36600

If Male, Please Complete This Box.

112 Are you able to have a full erection?

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

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

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

122 How long have you had difficulty with erectile function?

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

123 Is this difficulty getting:

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

36600

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

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

125 How severe is this sensitivity to bright light?

O 1 Mild O 2 Moderate O 3 Severe

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

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

127 How severe is this focusing problem?

O 1 Mild O 2 Moderate O 3 Severe

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

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

129 How severe is this blurred vision?

O 1 Mild O 2 Moderate O 3 Severe

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

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

131 How severe is this night vision problem?

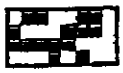
O 1 Mild O 2 Moderate O 3 Severe

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

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

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

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



36600

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

O 1 Yes O 2 No

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

O 1 Yes O 2 No

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

138 Narcolepsy? O 1 Yes O 2 No O 3 Don't know

139 Obstructive sleep apnea? O 1 Yes O 2 No O 3 Don't know

140 Abnormal or disordered sleep pattens? O 1 Yes O 2 No O 3 Don't know

141 Currently, how refreshing and restorative is your sleep?

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

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

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

O 1 Yes O 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)?

O 1 Yes O 2 No

[redacted] [redacted] [redacted]

36600

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._____

[redacted] [redacted]

[redacted] [redacted]

36600

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 over sensitive 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

[redacted]

[redacted]

36600

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.

[redacted]

[redacted]