1. Date history taken:

**General Immune/Infectious Symptoms**

1. At onset (within first month of illness), did participant/subject experience any of the following? If yes, are any of those symptoms current?(check all that apply)\*

Fevers  Current

Chills  Current

Night sweats  Current

Sore throats  Current

Swollen/tender glands  Current

Rashes  Current

Nausea/vomiting/diarrhea (N/V/D)  Current

Arthalgia/arthritis  Current

Mouth ulcers  Current

History of autoimmune disease  Current

Family history of autoimmune disease (biological relatives only, if applicable)  Current

1. Does the participant/subject have a history of repeated or long term antibiotic use?  Yes  No

If yes, what antibiotic(s):

Indication:

When (year(s)):

1. Does the participant/subject have a history of any of the following illnesses or conditions? (check all that apply, describe symptoms at onset)

|  |  |  |
| --- | --- | --- |
| **Condition** | **Symptoms at Onset** | **Year of Diagnosis** |
| Zoster |  |  |
| Immunodeficiency syndrome(s):  -Name of syndrome: |  |  |
| Malignancy (cancer) affecting the immune system:  -Name of syndrome: |  |  |

1. Food hypersensitivity

No

Yes

If yes, indicate which ones and type of reaction:

| **Food Component** | **Have Hypersensitivity?** | **Reaction (hives, vomiting, other)** | **Date of Onset** |
| --- | --- | --- | --- |
| Lactose |  |  |  |
| Gluten (any intolerance) |  |  |  |
| Gluten (celiac disease) |  |  |  |
| Milk protein |  |  |  |
| Alcohol |  |  |  |
| Eggs |  |  |  |
| Sugar/Fructose |  |  |  |
| Caffeine |  |  |  |
| Nuts |  |  |  |
| Chocolate |  |  |  |
| Aspartame |  |  |  |
| Other, specify: |  |  |  |

1. Adverse drug reactions (if yes, specify):

No

Yes:

If yes, list drugs and route and year(s) of administration:

|  |  |  |  |
| --- | --- | --- | --- |
| **Drug name** | **Route** | **Reaction** | **Year(s) received** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

1. History of atopy/allergic disorders

No

Yes

If yes, indicate which ones, whether a problem in the last year, whether currently a problem, whether you take medications for allergies :

|  |  |  |
| --- | --- | --- |
| **Condition diagnosis** | **If diagnosed:** | **Medication(s) name(s):** |
| Allergic rhinitis/hay fever | Condition active past one year  Condition currently active  Medications are taken for this condition  Medications taken daily for condition |  |
| Asthma | Condition active past one year  Condition currently active  Medications are taken for this condition  Medications taken daily for condition |  |
| Atopic dermatitis | Condition active past one year  Condition currently active  Medications are taken for this condition  Medications taken daily for condition |  |
| Hives | Condition active past one year  Condition currently active  Medications are taken for this condition  Medications taken daily for condition |  |
| Mast cell activation syndrome | Condition active past one year  Condition currently active  Medications are taken for this condition  Medications taken daily for condition |  |
| Other, specify: | Condition active past one year  Condition currently active  Medications are taken for this condition  Medications taken daily for condition |  |

1. History of unusual vaccines (e.g., related to international travel)

No

Yes

If yes, list which vaccines and year(s) of administration:

| **Vaccine Name** | **Years(s) Received** |
| --- | --- |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**Irritable Bowel Syndrome Criteria**

**ROME I Criteria\*\*:** At least 3 months of continuous or recurrent symptoms:

1. Abdominal pain or discomfort that is:

Relieved with defecation

and/or

Associated with a change in frequency of stool

and/or

Associated with a change in consistency of stool

***PLUS:***

2. Two or more of the following, on at least one-fourth of occasions or days:

Altered stool frequency (for research purposes, “altered” may be defined as more than three bowel movements each day or fewer than three bowel movements each week)

Altered stool form (lumpy and hard, or loose and watery)

Altered stool passage (straining, urgency, or a feeling of incomplete evacuation)

Passage of mucus

Bloating or feeling of abdominal

**Rome I criteria**:  YES  NO

.

**ROME II Criteria\*\*: Abdominal distention or pain** of at least 12 weeks duration (not necessarily consecutive weeks) in the preceding 12 months accompanied by two of the following three features of altered bowel habits:

Relieved with defecation

An onset associated with change in the frequency of stool

An onset associated with change in the form (appearance) of stool

**Rome II criteria**:  YES  NO

**ROME III Diagnostic Criteria for Irritable Bowel Syndrome\*\*:**

Recurrent abdominal pain or discomfort at least 3 days per month for the past 3 months **AND** two or more of the following symptoms:

Improvement with defecation

Onset associated with a change in frequency of stool

An onset associated with change in the form (appearance) of stool

Meets Rome III Diagnostic Criteria for Irritable Bowel Syndrome:  YES  NO

**Irritable Bowel Syndrome (IBS) Subtypes by Predominant Stool Pattern**

**You must not be taking laxatives or antidiarrheal medicines that will change your bowel habits.**

**1. IBS with Constipation (IBS-C):**

Hard or lumpy stool (Type 1 or 2) with more than 25% of bowel movements, and loose or watery stools (Type 6 or 7) with less than 25% of bowel movements.

**2.IBS with Diarrhea (IBS-D):**

Loose or watery stools (Type 6 or 7) with more than 25% of bowel movements, and hard or lumpy stools (Type 1 or 2) with less than 25% of bowel movements.

**3. Mixed IBS (IBS-M):**

Hard or lumpy stool (Type 1 or 2) with more than 25% of bowel movement, plus loose or watery stool (Type 6 or 7) with more than 25%, of bowel movements.

**4. Unsubtyped IBS:**

Insufficient abnormality of stool consistency to meet criteria for IBS-C,IBS-D or IBS-M.

**Medical History Questionnaire**

Please check any EYE conditions that are still active and/or for which you are taking medications

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Condition Diagnosed** | **Year(s) of Diagnosis** | **Condition Active** | **Take Medications (past year)** | **Currently Take Medications** | **Medication name(s)** | **Medication(s) work well** | **Condition no longer active/resolved** |
| Optic neuritis |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Uveitis or scleritis |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Eye infections |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Dry eye |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Sjogren's syndrome |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Other, specify: |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |

Please check any EAR, NOSE and/or THROAT conditions that are still active and/or for which you are taking medications

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Condition Diagnosed** | **Year(s) of Diagnosis** | **Condition Active** | **Take Medications (past year)** | **Currently Take Medications** | **Medication name(s)** | **Medication(s) work well** | **Condition no longer active/resolved** |
| Chronic sinusitis |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Chronic rhinitis (runny nose) |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Impaired hearing |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Easy nasal bleeding |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Nasal allergies |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Chronically infected tonsils |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Tonsillectomy |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Hay fever |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Chronic/repeated otitis media (ear infections) |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Other, specify: |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |

Please check any LUNG conditions that are still active and/or for which you are taking medications

| **Condition Diagnosed** | **Year(s) of Diagnosis** | **Condition Active** | **Take Medications (past year)** | **Currently Take Medications** | **Medication name(s)** | **Medications work well** | **Condition no longer active/resolved** |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Pneumonia, ever |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Pneumonia in the past 12 weeks |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Pleurisy |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Asthma (as a child) |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Asthma (as an adult) |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Bronchitis |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Emphysema |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Chronic obstructive lung disease (COPD or COLD) |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Chronic restrictive lung disease |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Silicosis |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Asbestosis |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Other, specify: |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |

Please check any GUT conditions that are still active and/or for which you are taking medications

| **Condition Diagnosed** | **Year(s) of Diagnosis** | **Condition Active** | **Take Medications (past year)** | **Currently Take Medications** | **Medication name(s)** | **Medications work well** | **Condition no longer active/resolved** |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Peptic ulcer |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Hiatus hernia |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Hepatitis, type unspecified |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Hepatitis A |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Hepatitis B |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Hepatitis C |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Gall bladder disease |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Liver disease |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Cirrhosis |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Pancreatitis |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Chronic pancreatitis |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Celiac disease |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Irritable bowel syndrome |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Crohn's disease |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Ulcerative colitis |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Colorectal cancer |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Other, specify: |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |

Please check any SKIN conditions that are still active and/or for which you are taking medications

| **Condition Diagnosed** | **Year(s) of Diagnosis** | **Condition Active** | **Take Medications (past year)** | **Currently Take Medications** | **Medication name(s)** | **Medications work well** | **Condition no longer active/resolved** |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Hives |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Psoriasis |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Eczema |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Contact dermatitis |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Dermatomyositis |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Vasculitis |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Zoster |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Other allergic skin reactions |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Other, specify: |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |

Please check any BLOOD and/or IMMUNE SYSTEM conditions that are still active and/or for which you are taking medications

| **Condition Diagnosed** | **Year(s) of Diagnosis** | **Condition Active** | **Take Medications (past year)** | **Currently Take Medications** | **Medication name(s)** | **Medications work well** | **Condition no longer active/resolved** |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Anemia |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Sickle cell disease |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Thalassemia |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Hemochromatosis |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Myeloproliferative disorders (myelodysplasia) |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Other, specify: |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |

Please check any INFECTIONS conditions that are still active and/or for which you are taking medications

| **Condition Diagnosed** | **Year(s) of Diagnosis** | **Condition Active** | **Take Medications (past year)** | **Currently Take Medications** | **Medication name(s)** | **Medications work well** | **Condition no longer active/resolved** |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Mononucleosis |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Lyme disease, Specify type: |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| HIV/AIDS |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Fungal disease (not including fungus skin infection) |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Chronic parasitic infection |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Tuberculosis |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Syphilis |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Subacute bacterial endocarditis |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Sepsis, ever |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Sepsis in the past 12 weeks |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Osteomyelitis |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |
| Other, specify: |  | Yes  No | Yes  No | Yes  No |  | Yes  No  Not applicable |  |

Treatments received for any immune disorders?

Yes

No

GENERAL INSTRUCTIONS

Important note: Some of the data elements on this form are considered Core (as specified by an asterisk) and are required by all ME/CFS studies to collect. The remaining data elements are considered Exploratory (i.e., non-Core) and should only be collected if the research team considers them appropriate for their study.

\*Element is classified as Core

\*\*Element is classified as Supplemental – Highly Recommended

SPECIFIC INSTRUCTIONS

Please see the Data Dictionary for definitions for each of the data elements included in this CRF Module.