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.