1. Date Medical History Taken (mm/dd/yyyy):
2. Month/Year of first symptoms as confirmed by history obtained by the physician (mm/yyyy):
3. Month/Year of Initial Diagnosis (mm/yyyy):
4. Diagnostic Features/Criteria (as evident on clinical assessment of the patient):
5. 4-6 Hz Rest Tremor:  Present  Absent  Unknown
6. Bradykinesia:  Present  Absent  Unknown
7. Rigidity:  Present  Absent  Unknown
8. Asymmetric Onset:  Present  Absent  Unknown
9. Substantial Response to Dopaminergic Therapy:  Present  Absent  Unknown
10. Degree of Certainty of Diagnosis of PD:

Clinically established  Clinically probable

1. Initial motor symptoms, i.e., as described by the patient (Please check all that apply):

Tremor (including internal tremor)

Stiffness

Change in facial expression

Disturbances of dexterity

Micrographia

Weakness

Dystonia (specify symptoms)

1. Ambulatory/Axial Difficulties:

Freezing

Lack of arm swing

Leg dragging

Shuffling of gait

Postural imbalance (excluding falls) Falls

Slowness of gait

Other abnormality of posture or gait (other, specify)

1. Side of Body of Initial Symptoms:

Right  Left  Bilateral  Midline  Unknown

1. Dominant hand:

Right hand  Left hand  Both hands

## General Instructions

Medical history data are collected to help verify the inclusion and exclusion criteria (e.g., no history of cognitive disabilities), ensure the participant/subject receives the appropriate care, and describe the study population. The Parkinson’s disease Medical History CRF captures conditions specifically related to PD as opposed to a more general Medical History which captures conditions that occurred at some point in time within a protocol-defined period.

Important note: All of the data elements included on this CRF Module are classified as Core (i.e., strongly recommended for all Parkinson’s disease clinical studies to collect) except for two “Other, specify” data elements (Dystonia symptom text; Ambulatory axial difficulty abnormal posture gait other text) which are classified as Supplemental (i.e., non-Core) and should only be collected if the parent data elements are checked. Please see the Data Dictionary for element classifications.

## Specific Instructions

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

History can also be obtained from a family member, friend, or chart/ medical record. If the informant is unable to answer the question or is deemed unreliable (e.g., the participant/ subject has dementia) the history should be obtained from the medical record.

Additional instructions for the elements are already included on the CRF.