SIDE EFFECTS QUESTIONNAIRE

30-32 (1) FORM NUMBER

33 (2) VERSION

(518) 40 SEQUENCE

1. SHEP ID: (3) 22 23 - (4) 24 25 26 27 - (5) 28 29

2. Acrostic: (6) 41-46 [ ][ ][ ][ ][ ][ ]

3. Date of clinic visit to which this form applies: 36 37 Month / 38 39 Day / 34 35 Year (7)

4. Sequence number of clinic visit: 47 48 (8)

This form is required at all clinic visits after a SHEP medication is started or increased; at all visits where the participant responds positively to any of the general side effects questions, and at all Annual visits.

Since your last visit, have you had:	(a)	New since last visit? (b) 1=Yes 2=No	Frequency: (c) 1=once only 2=<weekly 3=2-6 x weekly 4=daily 5=constantly	Severity: (d) 1=Not troublesome 2=Troublesome 3=Intolerable	In the opinion of the SHEP clinician, is this due to the use of SHEP medications? (e) 1=Yes 2=Possibly 3=No
5. Unusual coldness or numbness of the hands or feet?	(9) Yes □ 1 No □ 2 49	(10) 50	(11) 51	(12) 52	(13) 53
6. Unusual skin rash or bruising?	(14) Yes □ 1 No □ 2 54	(15) 55	(16) 56	(17) 57	(18) 58 → (f) Is an acute skin rash present on physical exam? (19) Yes □ 1 Possibly □ 2 No □ 3 59
7. Any feelings of unsteadiness or imbalance?	(20) Yes □ 1 No □ 2 60	(21) 61	(22) 62	(23) 63	(24) 64
8. Faintness or light headedness when you stand up quickly?	(25) Yes □ 1 No □ 2 65	(26) 66	(27) 67	(28) 68	(29) 69 → (f) Is there an observable postural drop in blood pressure? (35) Yes □ 1 No □ 2 75
9. Loss of consciousness or passing out	Yes □ 1 (30) No □ 2 70	(31) 71	(32) 72	(33) 73	(34) 74
10. Falls?	Yes □ 1 (36) No □ 2 76	(37) 77	(38) 78	(39) 79	(40) 80
11. Fractures?	Yes □ 1 (41) No □ 2 81	(42) 82	(43) 83	(44) 84	(45) 85 → (f) Hip? Yes □ 1 No □ 2 (46) 86 (g) Spine? Yes □ 1 No □ 2 (47) 87 (h) Forearm? Yes □ 1 No □ 2 (48) 88

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12. Unusual pain in any joint?	49 Yes □ 1 → No □ 2	50 90	51 91	52 92	53 93 → (f) Are there physical signs of acute arthritis? Yes □ 1 Possibly □ 2 No □ 3 — 54 94
13. Muscle weakness or cramping?	95 55 Yes □ 1 → No □ 2	56 96	57 97	58 98	59 99
14. Excessive thirst?	100 60 Yes □ 1 → No □ 2	61 101	62 102	63 103	64 104
15. Loss of appetite?	105 65 Yes □ 1 → No □ 2	66 106	67 107	68 108	69 109
16. Nausea or vomiting?	110 70 Yes □ 1 → No □ 2	71 111	72 112	73 113	74 114
17. Unusual indigestion?	115 75 Yes □ 1 → No □ 2	76 116	77 117	78 118	79 119
18. Change in bowel habits?	120 80 Yes □ 1 → No □ 2	81 121	82 122	83 123	84 124
19. Tarry black stools or red blood in the stools?	125 85 Yes □ 1 → No □ 2 →	86 126	87 127	88 128	89 129
20. Heart beating unusually fast or skipping beats?	130 90 Yes □ 1 → No □ 2	91 131	92 132	93 133	94 134
21. Heart beating unusually slow?	135 95 Yes □ 1 → No □ 2	96 136	97 137	98 138	99 139 → (f) Is an arrhythmia present on physical exam? Yes □ 1 Possibly □ 2 No □ 3 — 105 145
22. Episodes of chest pain or heaviness in the chest?	140 100 Yes □ 1 → No □ 2	101 141	102 142	103 143	104 144

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23. Headaches so bad you had to stop what you were doing? 106 Yes ☐ 1 → No ☐ 2	107 146	108 148	149 109	150 110
24. Stuffy nose? 151 111 Yes ☐ 1 → No ☐ 2	112 152	113 153	154 114	155 115
25. Unusual shortness of breath or wheezing? 156 116 Yes ☐ 1 → No ☐ 2	117 157	118 158	159 119	160 120
26. Unusual tiredness or loss of pep? 122 Yes ☐ 1 → No ☐ 2	162 123 163	124 164	165 125	166 126
27. Swelling of the ankles? 127 167 Yes ☐ 1 → No ☐ 2	128 168	129 169	170 130	171 131
28. Feeling so depressed (sad or blue) that it interfered with your work, recreation or sleep? 133 Yes ☐ 1 → No ☐ 2	173 134 174	135 175	176 136	177 137
29. Any trouble with your memory or concentration? 178 138 Yes ☐ 1 → No ☐ 2	179 139	180 140	181 141	182 142
30. Nightmares? 183 143 Yes ☐ 1 → No ☐ 2	144 184	145 185	186 146	187 147
31. Any changes in your sexual activity? Yes ☐ 1 → No ☐ 2	148 188 149 189	150 190	191 151	192 152

(f) Is there evidence for bronchospasm on auscultation of the chest? 161 121 Yes ☐ 1 Possibly ☐ 2 No ☐ 3

(f) Is there evidence of CHF on physical exam? 172 132 Yes ☐ 1 Possibly ☐ 2 No ☐ 3

193 153 (f) Loss of interest Yes ☐ 1 No ☐ 2

194 154 (g) Decline in frequency? Yes ☐ 1 No ☐ 2

195 155 (h) Loss of enjoyment? Yes ☐ 1 No ☐ 2

(i) Functional impairment? 196 156 Yes ☐ 1 No ☐ 2

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32. Trouble going to sleep, or waking early and having trouble getting back to sleep?	Yes ☐ 1 → No ☐ 2 (157) 197	(158) ☐ 198	(159) ☐ 199	(160) ☐ 200	(161) ☐ 201	
33. Waking up in the night more frequently to urinate?	Yes ☐ 1 → No ☐ 2 (162) 202	(163) ☐ 203	(164) ☐ 204	205 (165) ☐	206 (166) ☐	
34. More worry or anxiety than usual?	Yes ☐ 1 → No ☐ 2 207 (167)	(168) 208	(169) 209	210 (170) ☐	211 (171) ☐	
35. Weakness or numbness on one side, or unexpected difficulties talking or thinking?	Yes ☐ 1 → No ☐ 2 (172) 212	(173) ☐ 213	(174) ☐ 214	215 (175) ☐	216 (176) ☐ → (f) Is there evidence of a stroke on physical exam? Yes ☐ 1 Possibly ☐ 2 No ☐ 3 217 (177)	
36. Other relevant symptoms: Specify: _____ _____ _____ 218	Yes ☐ 1 → No ☐ 2 (178)	☐ (179) 219	(180) ☐ 220	221 (181) ☐	222 (182) ☐ → (f) Are there other relevant signs on physical exam? Yes ☐ 1 Possibly ☐ 2 No ☐ 3 Specify: _____ _____ 223 (183)	

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