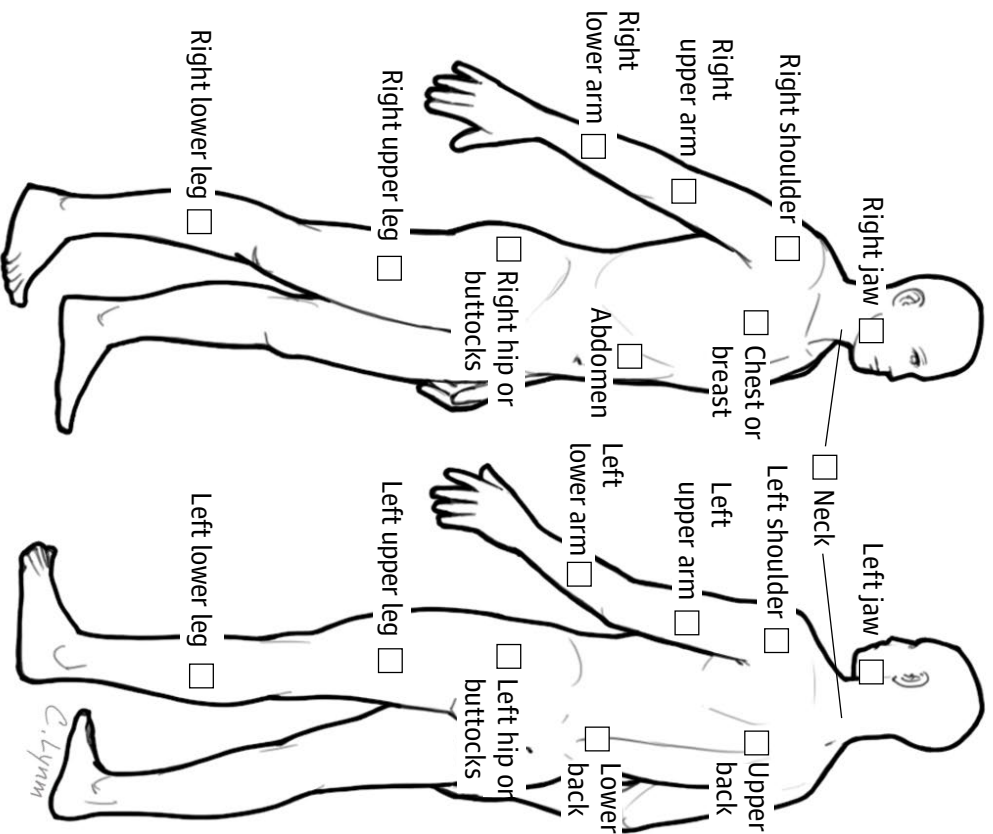


1 Please indicate if you have had pain or tenderness during the past 7 days in the areas shown below. Check the boxes in the diagram for each area in which you have had pain or tenderness.



2 For each symptom listed below, use the following scale to indicate the severity of the symptom during the past 7 days.

- No problem
- Slight or mild problem: generally mild or intermittent
- Moderate problem: considerable problems; often present and/or at a moderate level
- Severe problem: continuous, life-disturbing problems

	No problem	Slight or mild problem	Moderate problem	Severe problem
A. Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Trouble thinking or remembering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Waking up tired (unrefreshed)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3 During the past 6 months have you had any of the following symptoms?

- | | | |
|------------------------------------|-----------------------------|------------------------------|
| A. Pain or cramps in lower abdomen | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| B. Depression | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| C. Headache | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

4 Have the symptoms in questions 2-3 and pain been present at a similar level for at least 3 months?

- No Yes