PARTICIPANT HISTORY QUESTIONNAIRE (PHQ)

NOTE: Instructions for Study Coordinators are marked in blue ink.

The Participant History Questionnaire (PHQ) is a standardized questionnaire that has to be completed by each PNRR study participant at the enrollment visit and all subsequent study visits. The PHQ discusses the presence and severity of common PN symptoms, the impact of PN on the participant's ability to perform tasks of daily living, as well as other medical conditions and medication intake. In addition, the PHQ includes information about medical and family history.

Note: After the research participant has completed the questionnaire, the study coordinator should check that all questions were answered and obtain any missing information.

Participant Instructions (in questionnaire):

Read each question carefully and answer as thoroughly and accurately as possible. We are aware that some of these questions are sensitive in nature, and you might not be comfortable answering them. However, they are important assessments to evaluate the extent and severity of your symptoms associated with your peripheral neuropathy and, thus, important for our research.

If you are unsure how to fill out any part of this questionnaire, please do not hesitate to ask for help and guidance from the study team.

Section I. PARTICIPANT INFORMATION

What year were you born? _____ The year participant was born.

What is your sex?

Possible Answers:

- ☐ **Male**: genetic sex at birth was male
- ☐ **Female**: genetic sex at birth was female

Are you Hispanic or Latino?

Possible answers:

- ☐ **Yes:** participant is of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin, regardless of race
- ☐ **No:** participant is not of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin.

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What is your race? Mark only one.

Possible answers:

- ☐ **American Indian / Alaska Native**: participant is a descendent of any of the original peoples of North or South America (including Central America) and maintains tribal affiliation or community attachment
- ☐ **Asian**: participant is of Far Eastern, Indian or Southeast Asian descent
- ☐ **Black or African American**: participant is a descendent of a black racial group of Africa
- ☐ **Native Hawaiian or other Pacific Islander**: participant has origins of a Pacific island or Hawaii
- ☐ **White**: participant is of European, Middle Eastern or North African descent
- ☐ **More than one race**: participant is of mixed race

Are you right- or left-handed?

Possible answers:

- ☐ **Right**: participant is right-handed
- ☐ **Left**: participant is left-handed
- ☐ **Ambidextrous**: participant does not have dominant hand

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Section II. CURRENT SYMPTOMS

1. ***When did you notice the first symptoms associated with your peripheral neuropathy?***
_____ (month/year)

Number of years since participant noticed initial PN symptoms, recorded with one decimal, e.g. 3.5

b. ***What was your <u>initial symptom</u> associated with your peripheral neuropathy?***

Possible answers:

- ☐ **Discomfort / Tingling**: initial symptom was discomfort or tingling sensations.
- ☐ **Neuropathic pain**: painful sensations caused by axonal degeneration
- ☐ **Numbness**: loss of sensation
- ☐ **Autonomic symptoms**: such as frequent diarrhea or constipation, dry eyes or dry mouth, fainting, or abnormal sweating
- ☐ **Muscle cramping**: more frequent muscle cramps or muscle cramps starting
- ☐ **Balance issues / falls**: balance issues in form of stumbles, near falls or falls
- ☐ **Weakness**: muscular weakness or perceived muscular weakness
- ☐ **Other:** any other initial symptom. Participants should describe their initial symptom.

2. ***<u>PAIN:</u> Do you have pain or painful discomfort from your polyneuropathy?***

Possible Answers:

- ☐ **Yes**: participant has painful neuropathy
- ☐ **No**: participant's neuropathy is not painful

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► If you do NOT have pain, skip to **Question 3** (on Page 6)

a. When did you first experience neuropathic pain? _____ (month/year)

Information provided by participant when they first experienced neuropathic pain should be converted into years elapse since onset of pain and information should be entered in number of years with one decimal, e.g. 2.5

b. *Where is your neuropathic pain located? Mark all areas that apply.*

Participant to identify the areas of neuropathic pain.

Possible answers:

- ☐ **Left foot**: below left ankle
- ☐ **Left lower leg (below knee)**: between ankle and knee of left leg
- ☐ **Left upper leg (knee and above)**: between knee and groin of left leg
- ☐ **Left hand**: neuropathic pain in fingers or hand
- ☐ **Left lower arm (below elbow)**: between wrist and below elbow
- ☐ **Left upper arm (elbow and above)**: between elbow and shoulder joint on left arm
- ☐ **Right hand**: neuropathic pain anywhere below (distal of) right wrist
- ☐ **Front of torso**: participant experiences pain on torso/trunk, which is the main part of the body excluding the extremities, head and neck
- ☐ **Back of torso**: back only
- ☐ **Right foot**: below left ankle
- ☐ **Right lower leg (below knee)**: between ankle and knee of right leg
- ☐ **Right upper leg (knee and above)**: between knee and groin of right leg
- ☐ **Right hand**: neuropathic pain in fingers or hand
- ☐ **Right lower arm (below elbow)**: between wrist and below elbow
- ☐ **Right upper arm (elbow and above)**: between elbow and shoulder joint on right arm
- ☐ **Face**: on face
- ☐ **Neck**: in neck area

Note: If participant marks Torso/trunk, face, back or neck, the study coordinator should make sure that this pain is neuropathy related and not associated with another medical condition.

c. *Do you also have lower back pain and/or neck pain?*

Possible Answers:

- ☐ **Lower back pain**: participant reports lower back pain
- ☐ **Neck pain**: participant reports neck pain

i) If you have lower back pain, is it radiation into one or both legs?

Possible Answers:

- ☐ **Not radiating**: lower back pain not radiating into legs
- ☐ **Right leg**: lower back pain radiates only into right leg
- ☐ **Left leg**: lower back pain radiates only into left leg

☐ **Both legs**: lower back pain radiates into both legs. If pain radiates frequently into one leg and only occasionally into the other, "both legs" should still be selected as answer.

d. Which of the following statements describes your pain pattern the best? Please read all the options first before answering the question.

Possible Answers:

☐ **Constant background pain with regular flare-up pain at distinct times of day (evening versus afternoon). If flare-up's are also caused by activities, then check this box as well:**
☐ **Constant background pain and flare-up pain due to activities (e.g. walking)**
☐ **Pain most intense when first getting out of bed**
☐ **Constant pain that does not vary much in intensity**
☐ **Occasional pain (sometimes pain, other times pain free)**

Participant Instruction:
For the next set of questions, place an "X" through the number that best describes your background or constant pain. If you have a prescription of neuropathic pain medication, please describe your pain while taking your medication as prescribed.

e. ***Please use the scale below to tell us how intense your background/constant pain is.***

f. ***Please use the scale below to tell us how sharp your background/constant pain feels. Words used to describe sharp feelings include "like a knife", "like a spike", "jabbing", or "like jolts".***

g. ***Please use the scale below to tell us how hot your pain feels. Words used to describe very hot pain include "burning" and "on fire".***

h. ***Please use the scale below to tell us how dull your pain feels. Words used to describe very dull pain include "like a dull toothache", "dull pain", "aching", and "like a bruise".***

i. ***Please use the scale below to tell us how cold your pain feels. Words used to describe very hot pain include "like ice" and "freezing".***

j. ***Please use the scale below to tell us how sensitive your skin is to light touch or clothing. Words used to describe sensitive skin include "like sunburned skin" and "raw skin".***

k. ***Please use the scale below to tell us how itchy your pain feels. Words used to describe itchy pain include "like poison oak" and "like a mosquito bite".***

Participant Instruction:
For the next set of questions, place an "X" through the number that best describes your flare-up pain. Describe the flare-up pain you experience while taking your prescribed neuropathic pain medications.

l. ***Please use the scale below to tell us how intense your background/constant pain is.***

m. ***Please use the scale below to tell us how <u>sharp</u> your background/constant pain feels. Words used to describe sharp feelings include "like a knife", "like a spike", "jabbing", or "like jolts".***

n. ***Please use the scale below to tell us how <u>hot</u> your pain feels. Words used to describe very hot pain include "burning" and "on fire".***

o. ***Please use the scale below to tell us how <u>dull</u> your pain feels. Words used to describe very dull pain include "like a dull toothache", "dull pain", "aching", and "like a bruise".***

p. ***Please use the scale below to tell us how <u>cold</u> your pain feels. Words used to describe very hot pain include "like ice" and "freezing".***

q. ***Please use the scale below to tell us how <u>sensitive</u> your skin is to light touch or clothing. Words used to describe sensitive skin include "like sunburned skin" and "raw skin".***

r. ***Please use the scale below to tell us how <u>itchy</u> your pain feels. Words used to describe itchy pain include "like poison oak" and "like a mosquito bite".***

s. ***Do you experience abnormal perceptions of pain or discomfort from a normally non-painful stimulus? For example, do you experience tingling, burning, discomfort or some other abnormal sensation when lightly touched?***

Possible answers:

- ☐ **Yes**: participant has allodynia / hypersensitivity
- ☐ **No**: participant does not have allodynia / hypersensitivity
- ☐ **Don't Know**

t. ***Are you taking medication for your neuropathic pain?***

Possible Answers:

- ☐ **Yes**: participant takes medication for neuropathic pain
- ☐ **No**: participant does not take pain medication
  - ► If you do <u>NOT</u> take medication, skip to **Question 3** (next Page)

u. ***Which of the following statements best describes the effectiveness of your neuropathic pain medication (in comparison to not taking any medication for pain)?***

Possible answers:

- ☐ Not effective, no or minimal pain reduction
- ☐ Pain reduced, but remains very intense and unpleasant
- ☐ Pain reduced to tolerable level
- ☐ Effective, pain reduced to "discomfort"
- ☐ Very effective, pain no longer an issue until medication wears off

v. ***Does your pain medication have any side effects?***

Possible Answers:

- ☐ Sleepiness, drowsiness (somnolence)
- ☐ Dizziness
- ☐ Weight gain
- ☐ Nausea, upset stomach
- ☐ Sexual dysfunction
- ☐ Other: _____
- ☐ No side effects

w. ***Have you ever used marijuana or CBD products such as smoking, consuming edibles, lotions, patches or creams to ease your neuropathic pain?***

Possible Answers:

- ☐ Yes, I currently use marijuana (smoke, THS edible products, THC lotions, patches, etc)
- ☐ Yes, I currently use CDB containing products (edible products, lotions, cream's, patches, etc)
- ☐ I used them in the past, but currently do not use them
  - ► Why did you stop: _____
- ☐ No, I have never used marijuana products

x. ***Have you taken other medications or supplements for your neuropathic pain in the past, and if so please tell us why you stopped taking those medications:***

Name of medication	Dosage of medication	Reason you stopped / switched
		☐ Side effects ☐ Medication was never effective ☐ Effectiveness tapered off over time ☐ Insurance coverage ☐ Other: _____

- **Name of medication:** name of the discontinued pain medications should be listed, using the pharmaceutical drug name as listed in the RXNorm medication dictionary. If the pharmaceutical drug name is not available in RXNorm, the brand name should be provided.
- **Dosage of medication:** dosage per intake and dosage frequency should be captured. For example "900 mg TID". Dosing frequency codes are provided in Attachment 1
- **Reason you stopped / switched:** reason participant stopped pain medications usage:
  - ☐ Side effects
  - ☐ Medication was never effective
  - ☐ Effectiveness of medication tapered off over time
  - ☐ Insurance coverage
  - ☐ Other: _____

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3. *<u>LOSS OF SENSATION</u>: Do you have loss of sensation (numbness)?*

Possible Answers:

- ☐ **Yes**: participant has areas of numbness
- ☐ **No**: participant does not experience numbness
  - ► If you do <u>NOT</u> have numbness, skip to **Question 4 (next page)**.

a. When did you first notice loss of sensation? _____ (month / year)

Note: study coordinator to calculate time elapse in years since participant first experienced loss of sensation from participant answer and enter calculated time elapse in years into REDcap database. E.g. participant enrolled in January 2025 indicates that he first experience loss of sensation in June 2020, then "4.5" (for 4.5 years) should be entered in REDcap.

b. *Where is your numbness (loss of sensation) located? Mark <u>all</u> areas that apply.*

Participant to identify the areas of neuropathic pain.

Possible answers:

- ☐ **Left foot**: below left ankle
- ☐ **Left lower leg (below knee)**: between ankle and below knee
- ☐ **Left upper leg (knee and above)**: between knee and groin
- ☐ **Left hand**: below wrist
- ☐ **Left lower arm (below elbow)**: between wrist and elbow
- ☐ **Left upper arm (elbow and above)**: between elbow and shoulder
- ☐ **Front of torso**: breast or abdominal area
- ☐ **Back**: back side of torso
- ☐ **Right foot** below right ankle
- ☐ **Right lower leg (below knee)**: between ankle and knee
- ☐ **Right upper leg (knee and above)**: between knee and groin
- ☐ **Right hand**: below wrist
- ☐ **Right lower arm (below elbow):** between wrist and elbow
- ☐ **Right upper arm (elbow and above)**: between elbow and shoulder
- ☐ **Face**: facial area
- ☐ **Neck**: neck area (front or back)

c. *Is your loss of sensation (numbness):*

- ☐ **Always present**: participant experiences numbness constantly
- ☐ **Intermittent**: participant experiences numbness, but it is not constant. Examples could be only during certain times of the day, or only after certain activities.

d. *When you are standing in the tub or shower and the water is only touching your feet, are you able to tell the difference between hot water and cold water?*

- ☐ **Yes**: participant can tell if water is hot or cold
- ☐ **No**: participant cannot tell if water is hot or cold

e. ***Have you ever had an open sore naut caused by physical injury on your feet?***

- ☐ **Yes**: participant has had an open sore at least once
- ☐ **No**: participant have never had an open sore on their feet

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4. ***Do you experience tight, painful contractions of your muscles? These are sometimes referred to as "cramps" or "charlie horse".***

Possible Answers:

- ☐ **Yes, daily or almost daily**
- ☐ **Yes, frequently (not daily but at least once a week)**
- ☐ **Yes, sometimes (at least once a month, but less than once a week)**
- ☐ **Yes, but rarely (less than once a month)**
- ☐ **No, never** ► If you do NOT have painful contraction, skip to next question.

a. ***Are your tight, painful contractions of your muscles controlled with medication (either prescription or over the counter supplements)?***

Possible Answers:

- ☐ **Yes**, participant takes medication to treat muscle cramps
- ☐ **No, medication does not work**
- ☐ **I do not take medication for my muscle cramps**

NOTE: if participant takes medication or supplement for muscle cramps, it is expected that muscle relaxant / supplemental intake medication is listed in medication list

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For the following questions, please refer only to those symptoms you have experienced due to your peripheral neuropathy during the past 7 days.

5. ***BALANCE: Do you have trouble with your balance or difficulties walking because of poor balance?***

Possible Answers:

- ☐ **Yes**: participant has impaired balance or difficulties walking
- ☐ **No**: participant does not experience balance impairment
  ► If you do NOT have trouble with your balance go to question 5b.

a. ***When did you first notice balance issues: _____ (month / year)***

b. ***Do you use any assistive devices when walking? Mark all that apply.***

Possible Answers:

- ☐ **Yes, I use shoe inserts**
- ☐ **Yes, I use orthotics**
- ☐ **Yes, I use cane or walking poles**

- ☐ **Yes, I use a walker**
- ☐ **Yes, I use a wheelchair**
- ☐ **No, I do not use any assistive devices**

c. ***Have you had any falls in the past year?***

Possible Answers:

- ☐ **Yes, I had falls in the past year ► How many? _____**
- ☐ **No falls, but I had at least one near fall**
- ☐ **No, I have not fallen and had no near falls**

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6. **AUTONOMIC:** ***Now we want to know a little bit about your autonomic system. Your autonomic system regulates things like heart rate, blood pressure, sweating, bowel function and sexual function.***

a. ***Do you experience spells of lightheadedness or dizziness as if you were going to faint?***

- ☐ **Yes**: participant experiences spells of lightheadedness or dizziness
- ☐ **No:** participant does not experience lightheadedness or dizziness
  ► If you do NOT have dizziness, skip to **Question 7b** (next Page)

If answered with yes:

i. Do your spells of lightheadedness or dizziness get worse after the following activities? Mark all that apply.

Possible Answers:

- ☐ **After standing up quickly**
- ☐ **After a hot bath or shower**
- ☐ **After standing for a long time**
- ☐ **After a large meal**
- ☐ **Other:_____**

ii. Have you ever fainted or "passed out" in the past year?

Possible Answers:

- ☐ **Yes, I have fainted in the past year. ► How many times? _____**
- ☐ **I have not fainted in the past year, but I have fainted in the past**
- ☐ **No, I have never fainted**

b. ***Do you have abnormal sweating? Mark all that apply.***

Possible Answers:

- ☐ **Yes, I sweat more after eating**
- ☐ **Yes, I sweat less in a warm environment**

☐ **Yes, I have other abnormal sweating, please explain** _____
☐ **No.** Participant does not have abnormal sweating

c. ***Do you experience dryness of your eyes or mouth?***

Possible Answers:

☐ **Yes, dry eyes ► Do you have prescription medication for it? ☐ Yes ☐ No**
☐ **Yes, dry mouth ► Do you have prescription medication for it? ☐ Yes ☐ No**
☐ **No**

Note: study coordinator to verify that medication is included in medication list.

d. ***Do you have frequently abnormal bowel movements (at least once a week)?***

Possible Answers:

☐ **Yes, I have frequent diarrhea**
☐ **Yes, I have frequent constipation**
☐ **No**

e. ***Do you have difficulty with urination, increased urgency or increased frequency for urination, not caused by an enlarged prostate or another medical condition?***

Possible Answers:

☐ **Yes, I often experience a sudden, immediate need to go to the bathroom (urgency)**
☐ **Yes, I have the urge to go to the bathroom frequently (frequency)**
☐ **Yes, I lose control of my bladder (incontinence)**
☐ **Yes, I have trouble emptying my bladder or initiating urination**
☐ **No, I don't have difficulties with urination**

f. In the past year, have you noticed color changes to your skin, such as red white or purple?
Possible Answers:

☐ **Yes, skin got redder / purplish**
☐ **Yes, skin got whiter**
☐ **No color changes**

g. ***MEN ONLY: Has your sexual function changed recently? Mark <u>all</u> that apply.***

Possible Answers:

☐ **Yes, I have been having difficulties with having erections**
☐ **Yes, I have been having difficulties having ejaculation**
☐ **No**

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7. ***SLEEP: Have you experienced sleeping difficulties?***

Possible Answers:

☐ **Yes**: participant has some sleeping difficulties
☐ **No**: no sleeping problems ► If you do NOT have sleeping difficulties, skip to **Question 8**.

a. ***Do you have difficulty falling asleep or staying asleep at night from pain due to your peripheral neuropathy?***

Possible Answers:

☐ **Yes**
☐ **No**

b. ***Are your PN-symptoms worse at night?***

Possible Answers:
☐ **Yes**
☐ **No**

c. ***Do you have an urge to move your legs at night that is accompanied or caused by unpleasant sensations?***
Possible Answers:
☐ **Yes**
☐ **No**

d. ***Are your sleeping difficulties controlled with medications?***

Possible Answers:

☐ **Yes**
☐ **No, medication does not work**
☐ **I do not take medication to treat sleeping difficulties**

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8. ***Below is a list of common symptoms associated with peripheral neuropathy. Please let us know how much each of those symptoms "bothers you" using the 0-10 scales below.***

a. Neuropathic pain
b. Discomfort from tingling or pins and needles sensations
c. Loss of sensation (numbness)
d. Weakness (loss of strength or power)
e. ***Balance problems***

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Section III: QUALITY OF LIFE

9. Below are some questions about how you feel and how things have been with you for the past four weeks. For each question, please give the answer that comes closest to the way you have been feeling.

Questions:

a. **Did you feel full of pep?**
b. **Have you been a very nervous person**
c. **Have you felt so down that nothing could cheer you up?**
d. **Have you felt calm and peaceful?**
e. **Did you have a lot of energy?**
f. **Have you been a happy person?**
g. **Did you feel tired?**

Possible Answers:

- ☐ **All of the time**
- ☐ **Most of the time**
- ☐ **A good bit of the time**
- ☐ **Some of the time**
- ☐ **A little of the time**
- ☐ **None of the time**

10. During the past 4 weeks, how much of your time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc)?

Possible Answers:

- ☐ **All of the time**
- ☐ **Most of the time**
- ☐ **A good bit of the time**
- ☐ **Some of the time**
- ☐ **A little of the time**
- ☐ **None of the time**

11. Do you experience pain when you are physically active?

Possible Answers:

- ☐ **Yes**
- ☐ **No**

12. Do your legs hurt when you walk?

Possible Answers:

- ☐ **Yes**
- ☐ **No**

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Section IV. MEDICATIONS, VITAMINS, AND SUPPLEMENTS

Participant instructions:

Please list all medications, vitamins, and supplements that you are currently taking.

Medication, Vitamin, or Supplement:

- The names of all current medications should be listed, using the pharmaceutical drug name as listed in the RXNorm medication dictionary. If the option is available, both the pharmaceutical drug name with the brand name of the prescribed drug in parenthesis should be entered.
- Vitamins should be listed by either by using the chemical name or by listing the vitamin name as listed in the RXNorm medication list.
- Supplements: all taken supplements should be listed using the generic description of the supplement, for example "turmeric oil"
- Medications and supplements that are not included in the RXNorm list, should be entered in one of the data entry fields not linked to the RXNorm medication dictionary (#31, 32 and 33)

Dosage:

- The daily dosage should be listed, followed by the abbreviation that indicates the frequency. For example, QD (latin: quaque die) for medications taken once a day. Frequency abbreviations can be found in Attachment 1.
- For multivitamins and supplements, it is acceptable to enter the information in form of volume measurements, e.g. "1 capsule QD"

Started taking:

- Year the participant started taking the medication

Note: Study coordinator to check provided medication list against medication intake listed in the medical records. If medications are listed "as taking" in the medical records, but were not listed by the participant in the PHQ, the discrepancy should be discussed with the participant and the medication list should be corrected as applicable by the study coordinator.

REDcap note: If medication information is deleted in REDcap, all subsequent entered medication information will be automatically deleted by REDcap. Therefore any wrongly entered medication information should be "replace" with the medication entered last and then the last data entry should be deleted.

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Section V. MEDICAL HISTORY

13. ***Please mark all that apply and let us know if you were diagnosed before, after or about at the same time you noticed the first symptoms of peripheral neuropathy:***

- ☐ **Allergies**
- ☐ **Anxiety**
- ☐ **Amyloidosis**
- ☐ **Asthma**
- ☐ **Benign prostatic hyperplasia (BPH)**
- ☐ **Cardiac disease**
  - ☐ Coronary artery disease
  - ☐ Atrial fibrillation (arrhythmia)
  - ☐ Heart attach
  - ☐ Other: _____

  Name of drug(s): _____
- ☐ **Cataracts**
- ☐ **Celiac disease**
- ☐ **Cervical spine disease Location: _____**
- ☐ **Chronic fatigue syndrome**
- ☐ **Crohn's disease**
- ☐ **Depression**
- ☐ **Diabetes Mellitus**
  - ☐ Type I
  - ☐ Type II
  - ☐ Prediabetes
- ☐ **Elevated cholesterol**
- ☐ **Elevated triglycerides**
- ☐ **Fibromyalgia**
- ☐ **Gastroesophagal reflex disease (GERD)**
- ☐ **Gout**
- ☐ **Hepatitis**
  - ☐ Hepatitis A
  - ☐ Hepatitis B
  - ☐ Hepatitis C

  Have you ever received Interferon treatments?
  - ☐ Yes
  - ☐ No
  - ☐ Don't know
- ☐ **Herniated disk Location: _____**
- ☐ **Hypertension**
- ☐ **Irritable bowel disease**
- ☐ **Liver disease**
- ☐ **Long-term COVID**
- ☐ **Lumbar spine disease Location:**

- ☐ **Migraines**
- ☐ **Osteoarthritis**
- ☐ **Peripheral vascular disease**
- ☐ **Restless leg syndrome**
- ☐ **Rheumatoid arthritis**
- ☐ **Sarcoidosis**
- ☐ **Shingles**
- ☐ **Sjögren's syndrome**
- ☐ **Sleep apnea**
- ☐ **Thyroid disease**
  - ☐ Hyper – participant had iodine treatment or takes methimazole medication
  - ☐ Hypo – participant takes levothyroxine sodium (Synthroid) medication
  - ☐ Don't know
- ☐ **Ulcerative colitis**
- ☐ **Vitamin B6 deficiency**
- ☐ **Vitamin B12 deficiency**

Diagnosis of each other medical condition in regard to onset of PN

- ☐ **Before PN onset**
- ☐ **After PN onset**
- ☐ **Same time**
- ☐ **Don't know**

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14. ***Do you have other medical conditions not included in the list? And when did they start in regard to your onset of peripheral neuropathy?***

List of other medical conditions not listed in question 13.

Start of each medical condition in relation to peripheral neuropathy onset:

Possible Answers:

- ☐ **Before PN onset**
- ☐ **After PN onset**
- ☐ **Same time**
- ☐ **Don't know**

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15. ***Were you ever diagnosed with cancer?***

- ☐ **Yes**
- ☐ **No**
- ☐ **Don't know**

► If yes, what type of cancer? _____

Did you receive chemotherapy?

- ☐ **Yes**
- ☐ **No**
- ☐ **Don't know**

► If you received chemotherapy, provide the names of the chemotherapy drugs:
_____

16. ***If you had major surgery, please list the type of surgery and when it was performed:***

- **List of surgeries.**
- **Year of surgery.**

Section VI: SOCIAL AND OCCUPATIONAL HISTORY

17. ***What is your current and past occupation?*** _____

18. ***What is your marital status?***

Possible Answers:

- ☐ **Single**
- ☐ **Married**
- ☐ **Widowed**
- ☐ **Divorced / Separated**

19. ***Which best describes you living situation?***

- ☐ **I live alone**
- ☐ **I live with my spouse / partner**
- ☐ **I live with relatives / roommate**

20. ***Have you had (now or in the past) any occupational exposure to hazardous chemicals?***

Possible Answers:

- ☐ **Yes ► If yes, which one(s)?** _____
- ☐ **No**

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21. ***Have you <u>ever</u> smoked?***

Possible Answers:

- ☐ **Yes, I <u>currently</u> smoke**

If YES, when did you start smoking (year/age)? _____
AND how many cigarettes/packs do you smoke per day? _____

Information will be used to calculate packyears.

☐ **Yes, I have smoked <u>in the past</u>**

If YES, when did you start smoking (year/age)? _____
AND when did you stop smoking (year/age)? _____
AND how many cigarettes/packs did you smoke per day? _____

Information will be used to calculate packyears.

☐ **No, I never smoked.**

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22. ***Do you currently drink alcohol or have drunk alcohol in the past, and how many drinks do/did you consume per week?*** *For this question, one drink is equal to one glass of wine, one bottle of beer, or one mixed drink.*

Possible Answers:

☐ **Yes, I <u>currently</u> drink**

If YES, how many <u>drinks per week</u>? _____

☐ **Yes, I have drunk alcohol <u>in the past</u>**

If YES, how many <u>drinks per week</u>? _____
AND at what age did you stop consuming alcohol? _____(years)

☐ **No**

<u>Section VII. FAMILY HISTORY</u>

Note: If exact age at the time of diagnosis is unknown, participant should provide best guess. Instead of 50's enter number 50, instead of "mid 50's" enter the value "55".

23. ***Do you have any blood-related family members with <u>peripheral neuropathy or other neurological conditions</u>?***

Possible Answers:

☐ **Yes**: other (blood-related) family members have neurological conditions

☐ **No**: no other (blood-related) family member has a neurological condition
►Skip to **next question**

☐ **Don't know**: participant does not know if any relatives have a neurological condition
►Skip to **next question**.

Please tell us more about your family members with peripheral neuropathy or other neurological conditions. In the table below, list their relationship to you (e.g. maternal aunt), neurological disease, and the age at which they were diagnosed. *See example.*

- **Relationship to you**: relationship to relative with peripheral neuropathy from view of participant.
- **Type of neurological condition**
- **Age at diagnosis:** estimated age at diagnosis or exact age if known.

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24. ***Do you have any blood-related family members with the following diseases or conditions: DIABETES, HIGH TRIGLYCERIDES or HIGH CHOLESTEROL?***

Possible Answers:

☐ **Yes**: one or more (blood-related) family members have either diabetes mellitus, elevated triglycerides or elevated cholesterol

☐ **No**: no (blood-related) family member has diabetes or elevated triglycerides or cholesterol
►Skip to **next question**

☐ **Don't know**: participant does not know if any relative has diabetes or elevated triglycerides or elevated cholesterol
►Skip to **next question**

Please tell us more about your blood-related family members with these diseases/conditions. In the table below, list their relationship to you (e.g. maternal aunt), type of disease/condition, and the age at which they were diagnosed with that disease or condition. *See example.*

- **Relationship to you**: relationship to relative with medical condition from view of participant.
- **Type of disease/condition:** if a relative has more than one condition, all applicable conditions should be listed in one line, e.g. diabetes and high cholesterol
- **Age at diagnosis:** exact or estimated age at the time of diagnosis

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PNRR-2 SOP for Participant History Questionnaire (PHQ)

Section VIII: EXERCISES

Please tell us about your exercise habits in the past two weeks. If you do not exercise on a regular basis, then please check this box:

☐ **I do not exercise regularly**

Aerobic Exercises:

- **Walking (for exercise) or hiking**
- **Jogging or running (including treadmill)**
- **Cycling, including stationary bike**
- **Fitness classes (Barre, CorePower)**
- **Water aerobics**
- **Swimming**
- **Stairmaster**
- **Thai Chi**
- **Other: _____**

Anaerobic Exercises:

- **Golf**
- **Stretching**
- **Yoga or Pilates**
- **Weight lifting and weight training**
- **Gardening and yard work**
- **Other: _____**

Activity evaluation:

- **How many times in the past two weeks did you: _____** (number)
- **On average, how many minutes per occasion _____(number)**
- **How intense would your rate the effort:**
  - ☐ **Low**
  - ☐ **Moderate**
  - ☐ **Hight**

Date Submitted:
Date should be entered when data entry was **completed** (= assumed final).

Form Status:

- 🔴 **Incomplete:** not all data is entered yet
- 🟡 **Unverified:** all data is entered, but waiting for confirmation for some data (for example, when waiting for confirmation about primary diagnosis pending lab results, the form should be considered unverified
- 🟢 **Complete:** all information is verified, no additional edits are anticipate

PNRR-2 SOP for Participant History Questionnaire (PHQ)

ATTACHMENT 1: Medication Frequency Codes

Frequency Code	Frequency Description
BID	Twice a day
BIW	Twice a week
HS	At bedtime
OTO	One time only
PRN	As needed
QH	Every hour
Q4H	Every 4 hours
Q6H	Every 6 hours
Q8H	Every 8 hours
Q12H	Every 12 hours
Q2WK	Every 2 weeks
Q3WK	Every 3 weeks
Q4WK	Every 4 weeks
Q6WK	Every 6 weeks
QD	Once a day
QID	4 times a day
QIW	4 times a week
QMO	Once a month
QOD	Every other day
QWK	Every week
TID	3 times a day
TIW	3 times a week
QPM	Each evening
QAM	Each morning