

Instructions for Using the PAERS as an Interview

All CAPTN studies use the PAERS to guide assessment of possible adverse events (AE). While the PAERS items represent clinically important drug-related AEs, a PAERS item that is endorsed by your patient may or may not represent a drug-related AE. For example, in a patient taking sertraline, nausea may be a drug-induced AE or it may be due to a viral illness. Hostility and irritability may be related to stress or may be a drug effect. The PAERS therefore captures any adverse event for later determination of its relationship to study medication.

There are four PAERS forms: (1) a child PAERS, (2) a parent PAERS, (3) a clinician PAERS, and (4) a PAERS clinician interview form. Ordinarily, it is best to review the child and the parent PAERS, and then to interview the patient and parent before completing the clinician PAERS. However, this may not always be possible because of time constraints or poor compliance. To allow for variability that comes with taking care of real patients, we provide two options for completing the PAERS, one that employs and one that does not rely on the child and parent forms. In both options, from the baseline visit forward, review of the PAERS with the child and parent is intended to be a teaching opportunity as well as a mechanism for AE ascertainment.

- In option 1, (Clinician PAERS), the physician first reviews the completed child and parent PAERS forms and then, guided by prior knowledge, conducts a verbal review of all PAERS items with the child and parent. In this option, more attention is spent on items that the child or parent endorse as present, but every item is touched on, even if only briefly. The physician then completes the PAERS clinician form for later data entry.
- Option 2 (PAERS Clinician Interview form) uses the PAERS as a semi-structured interview when the completed child and/or parent forms are not available for prior review. In this option then, the physician does a careful verbal review of all PAERS items with the child and the parent before completing the PAERS interview form for later data entry. To make the interview version of the PAERS easy to administer and to code, we provide a PAERS Clinician Interview form that includes the child probe questions as well as the clinician item wording. Remember that even though you use child friendly language to ask questions, the construct being measured is captured in the clinician terminology.

To summarize, the PAERS provides a convenient and simple way to ascertain possible drug-related adverse events. There are two options for completing the PAERS, one with and one without the child and parent PAERS forms. Both options require a systematic review of each PAERS item with the child and parent, but you are free to use the option that best suits your particular circumstances at each study visit.

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Study Enrollment/Baseline PAERS—Clinician Interview

Subject identification: _____
site ID _____ subject ID _____

Pediatric Adverse Event Rating Scale Clinician PAERS

Evaluation date: ____/____/____
day month year

#	Signs/Symptoms	Recently Present?	Currently Resolved?	Drug Related? 0 = No 1 = Study drug 2 = Other drug 3 = Drug:drug interaction	Severity? 1 = Mild 2 = Moderate 3 = Severe 4 = Extreme	Function Impaired?
1	Irritable or bad mood: <i>Irritability:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
2	Angry or hostile: <i>Angry or hostile mood:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
3	Sad or low mood: <i>Sad or depressed mood:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
4	Lack of interest: <i>Apathy:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
5	Feeling shut down or numb: <i>Restricted range of emotion:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
6	Mood swings: <i>Emotional lability:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
7	Anxious, tense, uptight: <i>Anxious mood:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
8	Lack of self control/impulsive: <i>Impulsive:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
9	Trouble paying attention or concentrating: <i>Trouble paying attention/concentrating:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
10	Racing thoughts: <i>Racing thoughts:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
11	Can't sit or stand still: <i>Motor restlessness:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
12	Tired/fatigued: <i>Fatigue:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
13	Sleep too much: <i>Hypersomnia:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
14	Trouble falling or staying asleep: <i>Insomnia:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes

Study Enrollment/Baseline PAERS—Clinician Interview

Subject identification: _____
site ID _____ subject ID _____

Pediatric Adverse Event Rating Scale Clinician PAERS (continued)

#	Signs/Symptoms	Recently Present?	Currently Resolved?	Drug Related? 0 = No 1 = Study drug 2 = Other drug 3 = Drug:drug interaction	Severity? 1 = Mild 2 = Moderate 3 = Severe 4 = Extreme	Function Impaired?
15	Thinking about or wanting to hurt yourself: <i>Suicidal ideation:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
16	Tried to hurt yourself: <i>Suicidal behavior:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
17	Hurt someone or something: <i>Assaultive/aggressive:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
18	Less hungry: <i>Decreased appetite:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
19	Lost weight: <i>Weight loss:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
20	Dry mouth: <i>Dry mouth:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
21	More thirsty: <i>Excessive thirst:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
22	Feeling hungry: <i>Increased appetite:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
23	Gained weight: <i>Weight gain:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
24	Muscles weak: <i>Muscle weakness:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
25	Muscles shake, stiff or cramp: <i>Dyskinesia, dystonia:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
26	Tics: <i>Tics:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
27	Fits or seizures: <i>Seizures:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
28	Unusually good mood or super happy: <i>Elevated mood:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes

Study Enrollment/Baseline PAERS—Clinician Interview

Subject identification: _____
site ID _____ subject ID _____

Pediatric Adverse Event Rating Scale Clinician PAERS (continued)

#	Signs/Symptoms	Recently Present?	Currently Resolved?	Drug Related? 0 = No 1 = Study drug 2 = Other drug 3 = Drug:drug interaction	Severity? 1 = Mild 2 = Moderate 3 = Severe 4 = Extreme	Function Impaired?
29	Seeing or hearing things that aren't there: <i>Hallucinations:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
30	Bruising or bleeding: <i>Bruising/bleeding:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
31	Pimples or acne: <i>Acne:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
32	Skin rash or irritation: <i>Rash:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
33	Breast pain, swelling, or leaking: <i>Breast disorder:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
34	Sexual problems: <i>Sexual dysfunction:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
35	Chest pain: <i>Chest pain:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
36	Heart racing or skipping beats: <i>Tachycardia/arrhythmia:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
37	Dizzy or light-headed: <i>Dizzy:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
38	Feeling faint or passing out: <i>Syncope:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
39	Stomach ache or cramps: <i>Abdominal pain:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
40	Nausea/sick to stomach: <i>Nausea:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
41	Throwing up/vomiting: <i>Vomiting:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
42	Diarrhea: <i>Diarrhea:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
43	Headache: <i>Headache:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
44	Other (specify): _____	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
45	Other (specify): _____	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes

Post-Baseline Assessment PAERS—Clinician Interview

Subject identification: _____ - _____
site ID subject ID

Pediatric Adverse Event Rating Scale Clinician PAERS						
Evaluation date: ____/____/____ day month year						
#	Signs/Symptoms	Recently Present?	Currently Resolved?	Drug Related? 0 = No 1 = Study drug 2 = Other drug 3 = Drug:drug interaction	Severity? 1 = Mild 2 = Moderate 3 = Severe 4 = Extreme	Function Impaired?
1	Irritable or bad mood: <i>Irritability:</i>	<input type="checkbox"/> Yes →	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> No <input type="checkbox"/> Yes
2	Angry or hostile: <i>Angry or hostile mood:</i>	<input type="checkbox"/> Yes →	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> No <input type="checkbox"/> Yes
3	Sad or low mood: <i>Sad or depressed mood:</i>	<input type="checkbox"/> Yes →	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> No <input type="checkbox"/> Yes
4	Lack of interest: <i>Apathy:</i>	<input type="checkbox"/> Yes →	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> No <input type="checkbox"/> Yes
5	Feeling shut down or numb: <i>Restricted range of emotion:</i>	<input type="checkbox"/> Yes →	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> No <input type="checkbox"/> Yes
6	Mood swings: <i>Emotional lability:</i>	<input type="checkbox"/> Yes →	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> No <input type="checkbox"/> Yes
7	Anxious, tense, uptight: <i>Anxious mood:</i>	<input type="checkbox"/> Yes →	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> No <input type="checkbox"/> Yes
8	Lack of self control/impulsive: <i>Impulsive:</i>	<input type="checkbox"/> Yes →	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> No <input type="checkbox"/> Yes
9	Trouble paying attention or concentrating: <i>Trouble paying attention/concentrating:</i>	<input type="checkbox"/> Yes →	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> No <input type="checkbox"/> Yes
10	Racing thoughts: <i>Racing thoughts:</i>	<input type="checkbox"/> Yes →	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> No <input type="checkbox"/> Yes
11	Can't sit or stand still: <i>Motor restlessness:</i>	<input type="checkbox"/> Yes →	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> No <input type="checkbox"/> Yes
12	Tired/fatigued: <i>Fatigue:</i>	<input type="checkbox"/> Yes →	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> No <input type="checkbox"/> Yes
13	Sleep too much: <i>Hypersomnia:</i>	<input type="checkbox"/> Yes →	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> No <input type="checkbox"/> Yes
14	Trouble falling or staying asleep: <i>Insomnia:</i>	<input type="checkbox"/> Yes →	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> No <input type="checkbox"/> Yes

Post-Baseline Assessment PAERS—Clinician Interview

Subject identification: _____
site ID _____ subject ID _____

Pediatric Adverse Event Rating Scale Clinician PAERS (continued)

#	Signs/Symptoms	Recently Present?	Currently Resolved?	Drug Related? 0 = No 1 = Study drug 2 = Other drug 3 = Drug:drug interaction	Severity? 1 = Mild 2 = Moderate 3 = Severe 4 = Extreme	Function Impaired?
15	Thinking about or wanting to hurt yourself: <i>Suicidal ideation:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
16	Tried to hurt yourself: <i>Suicidal behavior:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
17	Hurt someone or something: <i>Assaultive/aggressive:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
18	Less hungry: <i>Decreased appetite:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
19	Lost weight: <i>Weight loss:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
20	Dry mouth: <i>Dry mouth:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
21	More thirsty: <i>Excessive thirst:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
22	Feeling hungry: <i>Increased appetite:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
23	Gained weight: <i>Weight gain:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
24	Muscles weak: <i>Muscle weakness:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
25	Muscles shake, stiff or cramp: <i>Dyskinesia, dystonia:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
26	Tics: <i>Tics:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
27	Fits or seizures: <i>Seizures:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
28	Unusually good mood or super happy: <i>Elevated mood:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes

Post-Baseline Assessment PAERS—Clinician Interview

Subject identification: _____
site ID _____ subject ID _____

Pediatric Adverse Event Rating Scale Clinician PAERS (continued)

#	Signs/Symptoms	Recently Present?	Currently Resolved?	Drug Related? 0 = No 1 = Study drug 2 = Other drug 3 = Drug:drug interaction	Severity? 1 = Mild 2 = Moderate 3 = Severe 4 = Extreme	Function Impaired?
29	Seeing or hearing things that aren't there: <i>Hallucinations:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
30	Bruising or bleeding: <i>Bruising/bleeding:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
31	Pimples or acne: <i>Acne:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
32	Skin rash or irritation: <i>Rash:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
33	Breast pain, swelling, or leaking: <i>Breast disorder:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
34	Sexual problems: <i>Sexual dysfunction:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
35	Chest pain: <i>Chest pain:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
36	Heart racing or skipping beats: <i>Tachycardia/arrhythmia:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
37	Dizzy or light-headed: <i>Dizzy:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
38	Feeling faint or passing out: <i>Syncope:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
39	Stomach ache or cramps: <i>Abdominal pain:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
40	Nausea/sick to stomach: <i>Nausea:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
41	Throwing up/vomiting: <i>Vomiting:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
42	Diarrhea: <i>Diarrhea:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
43	Headache: <i>Headache:</i>	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
44	Other (specify): _____	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
45	Other (specify): _____	<input type="checkbox"/> ₁ Yes →	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes