Date: _____ Participant ID: _____

Participant Information

Demographics

Age: _____

Sex: _____

Height: _____

Parkinson's patient participants only

Age of PD onset: _____

Year of Diagnosis: _____

Initial PD symptoms:

Medications: type & dose

Name	Indication	Dosage	Frequency	Total

Do you take any antidepressant medication? YES/NO (please indicate type)

Do you take any benzodiazepines or anti-seizure medication? YES/NO (please indicate type)

Do you take a sleep aid? YES/NO (please indicate type)

When was the last time you used antibiotics? _____

Approximately, how many times have you used antibiotics in the past 5 years? _____

NSAIDs: Do you take or have you previously regularly taken non-steroidal anti-inflammatory medication (NSAIDs) i.e. Ibuprofen, Advil etc.?

Over the counter NSAIDs?

- ☐ YES
- ☐ NO
- ☐ Previously

IF YES:

1. When did you start taking these? _____
2. How often did you take these and for how long? _____

IF Previously:

1. When did you start taking these? _____
2. How often did you take these and for how long? _____
3. When did you stop taking these? _____

Prescribed NSAIDs?

- ☐ YES
- ☐ NO
- ☐ Previously

IF YES:

1. When did you start taking these? _____
2. How often did you take these and for how long? _____

If Previously:

1. When did you start taking these? _____
2. How often did you take these and for how long? _____
3. When did you stop taking these? _____

History of Metal/Medical Implants/Devices,

1. Do you have any of the following devices?

- ☐ artificial heart valve;
- ☐ brain aneurysm clip;
- ☐ electrical stimulator for nerves or bones;
- ☐ ear or eye implant;
- ☐ implanted drug infusion pump;
- ☐ coil, catheter, or filter in any blood vessel;
- ☐ orthopedic hardware (artificial joint, plate, screws);

- ☐ other metallic prostheses;
- ☐ shrapnel, bullets, or other metal fragments;
- ☐ surgery or tattoos (including tattooed eyeliner) in the last six weeks;
- ☐ cardiac pacemaker, wires or defibrillator;
- ☐ ferromagnetic aneurysm clip

2. Have you ever had an injury where a piece of metal lodged in your eye?

   a. Yes

   b. No

3. If **YES**, please explain. _____

History of Smoking

1. Do you smoke?
   a. Yes
   b. No
   c. Previously

2. If **YES**, for how long?

3. If **YES**, how many cigarettes per day?

4. If previously, when?

5. If previously, how many cigarettes per day?

History of Alcohol Use

3. Do you consume alcohol?
   a. Yes
   b. No
   c. Previously
4. If yes, how much on a weekly basis (drinks/week)? _____
   a. For how long? _____
5. If previously, how much on a weekly basis (drinks/week)? _____
   a. For how long? _____

Additional Comments:

Rural Living

1. Have you ever lived or worked on or next to a farm?
    a. Yes
    b. No
2. If YES, when and for how long (please provide details)?

3. If YES, did this farm do crop dusting? YES/NO
4. If YES, did you have significant exposure to pesticides or herbicides? YES/NO

Occupation

Have you worked in the following occupation?

- ☐ Agriculture. # of years: _____
- ☐ Gas. # of years: _____
- ☐ Electricity. # of years: _____
- ☐ Water and Sewer. # of years: _____
- ☐ Transportation. # of years: _____
- ☐ Mining. # of years: _____
- ☐ Construction. # of years: _____
- ☐ Manufacturing. # of years: _____
- ☐ Physician or nurse. # of years: _____
- ☐ Office job. # of years: _____
- ☐ Other: _____ # of years: _____
- ☐ Work from home. # of years: _____

Have you worked with solvents/chemicals?

1. YES
2. NO

If YES,

Type of chemical(s)/solvent(s): _____

How old were you when you started working with these: _____ (age)

How long: _____ (years)

Did you wear protective gear? YES/NO

Have you had any military exposure? YES/NO

Additional Comments:

Family History

Did you immigrate to Canada? YES/NO

If YES, where from? _____

If NO, please see below:

From what country did you father's ancestors immigrate to Canada?

_____

From what country did you mother's ancestors immigrate to Canada?

_____

What ethnicity do you most identify yourself with?

- ☐ Caucasian
- ☐ South-East Asian
- ☐ South Asian
- ☐ West Asian
- ☐ Arab
- ☐ East Asian
- ☐ Black and/or African
- ☐ Aboriginal/First Nations
- ☐ Latin American and/or Hispanic
- ☐ Other: _____

Do you have any blood relatives who have or had PD? YES/NO

If yes, for each relative who has PD, list the **relationship** to you?

1. Maternal/Paternal_____
2. Maternal/Paternal_____
3. Maternal/Paternal_____

4. Maternal/Paternal_____

Do you have any blood relatives who have RBD, Colitis, Crohn's disease or celiac disease? ? YES/NO

If yes, for each relative who had or has any of the conditions, list the **condition** and their **relationship** to you?

1. Maternal/Paternal_____
2. Maternal/Paternal_____
3. Maternal/Paternal_____
4. Maternal/Paternal_____

Have you had genetic testing done? YES/NO

If applicable, type of test: commercial/clinical/research/other; _____

Mutation: _____

When you disclose results from genetic testing for research, you are sharing genetic information, not only about yourself, but also about biological (blood) relatives who share your genes or DNA. The risk of your information being accidentally released in this study is estimated to be extremely low. A recently passed Federal (Canada-wide) law now prohibits anyone such as an employer or an insurer from requiring you to disclose the results of a genetic test or to take a genetic test as condition of providing services. In addition, discrimination against individuals based upon genetic characteristics is now prohibited by the Canadian Human Rights Act.

ID:_____

Past Medical History

Question	YES/NO	If yes, please provide further detail:
Were you born by C-section?		
Have you previously had a head injury or repeated blows to the head from e.g. playing sports?		
Have you had a stroke, ataxia, MS, AD, dementia, dystonia, autism, bipolar disorder, ALS, or epilepsy?		
Have you had your tonsils removed?		
Have you had your appendix removed?		
Do you have an autoimmune condition?		
Do you have Irritable Bowel Disease (IBS) or spastic colon?		
Do you have Inflammatory Bowel Disease (IBD)?		
Do you have Small Intestinal Bacterial Overgrowth?		
Do you have an ulcer or have you previously had an ulcer?		
Do you have celiac disease?		
Do you have Crohn's disease?		
Do you have colitis?		
Do you have cancer of the digestive system or have you previously had cancer of the digestive system?		
Do you have diabetes?		
Do you have high/low cholesterol?		
Do you have high/low blood pressure?		
Do you have or have you previously had depression, anxiety or a mood disorder?		
Have you previously or do you currently suffer from indigestion or reflux at least once a week?		
Are you often constipated (fewer than 3 bowel movements per week)?		
Do you often have diarrhea (once a week or more)?		
Have you lost more than 10 lb in the last year?		

Have you gained more than 10 lb in the last year?		

Open-ended Questions:

Ask the participant if they have had any of the medical problems listed on the left that have not been addressed above and then list some examples within the category. Write down anything pertaining to the category, even if it's not one of the conditions listed.
E.g. "Have you previously or do you currently have any issues with your heart, such as a heart attack, angina or heart failure?"

1. Cardiac (heart attack, angina, heart failure, arrhythmias, heart murmurs)	
2. Vascular (Blood, blood vessels and cells, marrow, spleen, lymphatic system)	
3. Respiratory (asthma, COPD, emphysema, lung cancer)	
4. ENT (eye, ear, nose, throat, larynx)	
5. GI (esophagus, stomach, gallbladder, appendix, pancreas, intestines, GI bleed, hernia)	
6. Hepatic (liver failure)	
7. Renal (kidney infections, kidney failure, kidney stone)	
8. Urinary and Reproductive (bladder infections, prostate conditions, endometriosis, C-sections)	
9. Musculo-Skeletal-Integumentary (osteoporosis, muscle pain, skin conditions)	
10. Neurologic (spinal cord, nerve)	

11. Endocrine-Metabolic (obesity, toxicity, thyroid dysfunction)	
12. Rheumatologic (rheumatoid arthritis, inflammatory joint disease, lupus)	
13. Cancers (skin, prostate, lung, breast)	
14. Psychiatric (agitation, psychosis, substance abuse)	
15. Allergies (environmental, seasonal, animals, dust mites, foods, medications)	
16. Chronic/Acute Infectious diseases (hepatitis A/B/C, HIV, malaria)	
17. Other (surgeries or conditions)	

ID: _____ Date: _____

Apathy Scale

Please read each statement carefully. For each statement, please tick the column that best describes how you have been feeling in the last two weeks.

	Not at all	Slightly	Some	A lot
1. Are you interested in learning new things?				
2. Does anything interest you?				
3. Are you concerned about your condition?				
4. Do you put much effort into things?				
5. Are you always looking for something to do?				
6. Do you have plans and goals for the future?				
7. Do you have motivation?				
8. Do you have the energy for daily activities?				
9. Does someone have to tell you what to do each day?				
10. Are you indifferent to things?				
11. Are you unconcerned with many things?				
12. Do you need a push to get started on things?				
13. Are you neither happy nor sad, just in between?				
14. Would you consider yourself apathetic?				