Questionnaire for the Detection of Autoimmune Associated Symptoms and Factors (FAISF)

Introduction

Dear Study Participant,

Thank you for participating in this study.
You have been diagnosed with a psychiatric illness. In some cases, such diseases are an expression of an autoimmune disease. An autoimmune disease can affect many organs so that the patient complains about different and often mild symptoms. Sometimes patients pay no attention to the symptoms, because there is no physical constraint in daily life.

This "mosaic" of different symptoms is often recognized very late as an expression of autoimmune disease. With the help of this Questionnaire your physician can collect indications for a possible autoimmune disease. The following questions focus on the most common symptoms of selected autoimmune diseases. This questionnaire cannot replace the personal consultation and the physical exam.

Nowadays it is believed that certain factors can cause autoimmune diseases. In addition, this questionnaire will detect such risk factors in your medical history.

The questionnaire is composed of different topics:

Chapter I (General History) concentrates on your medical history, as well as your family’s medical history. Here, also questions on environmental factors are raised.

Chapter II (Screening for Autoimmune Diseases) checks for symptoms of a possible autoimmune disease and deals with a selected number of common autoimmune diseases that might apply to you.

In the last chapter (Dermatological Anamnesis, Chapter III) we ask for possible current skin problems or skin manifestations in your past. As the questions are very extensive and the answers are numerous, we designed a separate chapter.

Finally, I’m asking you for an evaluation of the questionnaire (Evaluation, IV)

We try to avoid “medical language”, if possible, instead pictorial examples are being used. Some questions are very similar and seem to be repeated, especially in chapters II and III. Still, these questions are different and they differ in detail and are needed to systematically record your disease.

There are different types of answers. Some answers are multiple choice. The simplest answer form is a "yes / no" -type with only one option to choose. Furthermore, there are multiple choice answers, which allows you to choose more than only one fitting answer. You will find such questions mainly in Chapter III. Furthermore, there are open questions, especially in the psychiatric and social anamnesis in which you are allowed to answer freely without specification. Such questions are appropriately marked. If the answer to your questions does not fit in the allocated space, please use the back of the questionnaire. Frequently, there are also combinations of cross-marked and handwritten answers. Here is an example of how such an answer might look like:

58. Do you have recurrent inflammation of the eyes?

☐ No ☑ Yes, from 1998 to today

This questionnaire can be completed in a familiar setting, without any time pressure.
Anonymity is important. In order to be able to assign the questionnaire to you without doubt, I would like to ask you to enter your initials in the space provided for this purpose. Since I know the study participants, date of birth or other personal information is not required.

The questionnaire will be destroyed after the evaluation.

Each of these topics should take about 10 -15 minutes. If questions are unclear, please make a note under the relevant question and move on to the next one.

After you have filled out the entire questionnaire, you can deposit it with your doctor. I will collect it there.
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II Screening for Autoimmune Diseases

III. Dermatological Anamnesis

IV. Appendix with Evaluation
Your initials:  
Do you fill out this questionnaire yourself?  □ Yes □ No

I. General Medical History
I.a Somatic Anamnesis

1. Do you suffer from a chronic disease of the cardiovascular system (such as high blood pressure, angina pectoris, vascular calcification, cardiac arrhythmia, etc.)?
   □ No or unknown  
   □ Yes, I know the following (please specify)

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<th>Disease</th>
<th>Date of initial diagnosis</th>
<th>Initial treating diagnostician or institution</th>
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2. Do you suffer from a metabolic disease (such as thyroid dysfunction, diabetes, hormonal disease)?
   □ No or unknown  
   □ Yes, I know the following (please specify)

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3. Do you suffer from a malignant disease (tumor diseases such as colorectal cancer, breast cancer or malignant lymphoma)?
   □ No or unknown  
   □ Yes, I know the following (please specify)

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<th>Date of initial diagnosis</th>
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4. Do you suffer from other chronic diseases (rheumatism, skin diseases, gynecological diseases)?

- [ ] No or unknown
- [ ] Yes, I know the following (please specify)

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<th>Date of initial diagnosis</th>
<th>Initial treating diagnostician or institution</th>
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5. Have you ever had a life-threatening illness (heart attack, stroke) or an event with a longer hospital stay (acute heart failure)?

- [ ] No or unknown
- [ ] Yes, I know the following (please specify)

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<th>Initial treating diagnostician or institution</th>
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6. Have you ever had an infectious disease (hepatitis, AIDS, etc.)?

- [ ] No or unknown
- [ ] Yes, I know the following (please specify)

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7. Did you have childhood diseases (measles, rubella, chickenpox, etc.)?

- No or unknown
- Yes, I know the following (please specify)

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<th>Date of initial diagnosis</th>
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8. Have you been vaccinated?

- No or unknown
- Yes, I know the following (please specify)

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9. Any allergies known?

- No or unknown
- Yes, I know the following (please specify)

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<th>Allergic to...</th>
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10. Do you have a blood clotting disorders (factor V Leiden mutation, platelet deficiency, hemophilia) or do you have frequent bleedings in the skin?

- No or unknown
- Yes, I know the following (please specify)

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11. Have there been accidents, injuries, or operations performed in the past?

☐ No or unknown
☐ Yes, I know the following (please specify)

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<thead>
<tr>
<th>Type of event</th>
<th>Date</th>
<th>Treatment</th>
<th>Further course</th>
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12. Are there recognized disabilities or occupational diseases?

☐ No or unknown
☐ Yes, I know the following (please specify)

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<th>Type of disability/occupational disease</th>
<th>Initial treating diagnostician or Institution</th>
<th>Date</th>
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13. If you are a woman, how many births have you had?

☐ none

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<th>Date</th>
<th>Son or Daughter</th>
<th>Anomalies during birth</th>
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14. If you are a woman, did you have miscarriages?

☐ No or unknown
☐ Yes, I know the following (please specify)

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<th>Date</th>
<th>Known cause</th>
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15. If you are a woman, have you stopped a pregnancy prematurely?

☐ No
☐ Yes

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<th>Treating diagnostician or institution</th>
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16. If you are a woman, are you currently pregnant?

☐ No
☐ Yes, in the _____ week of pregnancy
I.b Family History

17. Are there any diseases in your family?

□ No or unknown
□ Yes, I know the following (please specify)

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<th>Family member</th>
<th>Disease</th>
<th>Date of initial diagnosis and duration of disease</th>
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I.c Psychiatric and Social History

18. Do you have or has there been a mental illness in your past?

□ No or unknown
□ Yes, I know the following (please specify)

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<th>Date of initial diagnosis and duration of disease</th>
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19. Do you remember abnormalities in your early childhood development? Free response:


20. Have you already had signs of mental illness in your childhood? Free response:


21. How would you describe the relationship with your parents and siblings in early years (longer separation of caregivers, existential threats, etc.)? Free response:


22. Have there been any unusual events in your academic and professional development (good / bad performance, frequent school truancy, class re-enrollment, etc.)? Free response:


23. Have there been abnormalities in your sexual development? Free response:


24. How would you describe your marriage / relationship or previous marriages / relationships? Free response:


25. Are there abnormalities in dealing with social contacts (loss of friendships, withdrawal from social life, etc.)? Free response:


26. How would you describe your relationship with the family today (solid or loose family ties, trust within the family, etc.)? Free response:


27. How would you describe your current life situation (job, stress, family, etc.)? Free response:


28. Do you regularly consume legal or illegal addictive substances (legal ones include cigarettes, coffee, sleeping aids, laxatives, etc.)?

☐ No or unknown
☐ Yes, I consume the following (please specify)

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I.e. Vegetative Functions

29. Are there abnormalities in your eating habits (loss of appetite, avoiding certain foods, binge eating, etc.)? Free response:

30. Do you have a regular bowel movement?
   - □ No
   - □ Yes

31. If you are a woman: Is there / has there been any irregularity in your menstruation?
   - □ No
   - □ Yes (please specify as a free response)

32. If you are a woman, have you already entered menopause?
   - □ No
   - □ Yes, since the age of _____

I.f Medication History

33. Please document the medications you are currently using on a regular basis (also not prescribed medications, homeopathic remedies, anti-baby pill, etc.)

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II Screening for Autoimmune Diseases

34. Do you suffer from fatigue, nocturnal sweating or muscle pain?
   □ No    □ Yes, from ___ to ___   (please underline the corresponding symptom)

35. Do you suffer from painful changes in one or more joints or multiple joints without any apparent cause (such as accident or overuse)?
   □ No    □ Yes, from ___ to ___   (please underline the corresponding symptom)

If yes, please mark the corresponding joints in the sketch (be sure to consider both sides of the body as well as symmetrical and asymmetrical joint pain).

35.1 Was this pain associated with swelling?
   □ No    □ Yes

35.2 Are more than three of these joints affected?
   □ No    □ Yes

35.3 Were these pains symmetrical?
   □ No    □ Yes
35.4  Do you suffer from morning stiffness of these joints and do you have difficulties to stretch and bend these joints in the morning?
□ No  □ Yes

36. Have you ever noticed nodular, painful lesions on the elbows?
□ No  □ Yes

37. Do you suffer from psoriasis, do you have 1st or 2nd grade family members with psoriasis?
□ No
□ Yes, I suffer from psoriasis since ___
□ Yes, I have 1st or 2nd grade family members with psoriasis.

38. Have you noticed any changes in the fingernail or toenail (such as destruction, discoloration, loosening and separation of the nail)?
□ No  □ Yes, from ___ to ___

39. Do you suffer from a painful swelling of an entire finger ("sausage finger"), or an entire toe?
□ No  □ Yes, from ___ to ___

40. Have you ever suffered from inflammation of the tendons, especially the heel tendon?
□ No  □ Yes, from ___ to ___
41. Do you suffer from chronic back pain for more than 3 months?

□ No  □ Yes, from ___ to ___

41.1 If yes, is this pain deep seated (down to the buttocks)?

□ No  □ Yes

41.2 If yes, is your motion restricted in your back?

□ No  □ Yes

41.3 If yes, has this back pain occurred before the age of 45?

□ No  □ Yes

41.4 If yes, does this backpain occur especially early in the morning?

□ No  □ Yes

41.5 If yes, does the back feel stiff for more than 30 minutes?

□ No  □ Yes

41.6. If so, does the pain improve with moving?

□ No  □ Yes

42. Have you ever had a rash on your face, as pictured in the sketch?

□ No  □ Yes, from ___ to ___

43. Do you suffer from rashes, blisters or skin swelling caused by light?

□ No  □ Yes, from ___ to ___
44. Have you ever had a renal disease (for example too much protein released into the urine)?
   □ No  □ Yes, from ___ to ___

45. Have you ever had a painful skin change like the one shown in the picture?
   □ No  □ Yes, from ___ to ___

45.1 If yes, does it occur in the cold?
   □ No  □ Yes

46. Do you suffer from neurological disorders (such as seizures, neurological speech disorders, movement disorders, neurological dizziness or neurological vision problems)?
   □ No  □ Yes

47. Have you ever suffered from local inflammations and excavations on the mucosa of the mouth or nose?
   □ No  □ Yes, from ___ to ___

48. Have you ever suffered from unintended weight loss?
   □ No  □ Yes, from ___ to ___

49. Have you ever suffered from a dry mouth for more than 3 months?
   □ No  □ Yes, from ___ to ___
50. Have you ever suffered from muscle weakness, especially in arms and legs?
   □ No  □ Yes, from ___ to ___

51. Have you ever suffered from a weakness of swallowing?
   □ No  □ Yes, from ___ to ___

52. Have you ever had a nasal speech?
   □ No  □ Yes, from ___ to ___

53. Have you ever suffered from a weakness of breathing?
   □ No  □ Yes, from ___ to ___

54. Have you ever had frequent infections of the upper respiratory tract or constant coughing?
   □ No  □ Yes, from ___ to ___

55. Have you ever had periods of frequent headache?
   □ No  □ Yes, from ___ to ___

56. Have you ever had a feeling of dry eyes, for more than 3 months?
   □ No  □ Yes, from ___ to ___

57. Have you ever had a foreign body sensation in your eyes?
   □ No  □ Yes, from ___ to ___

58. Do you have recurrent inflammation of the eyes?
   □ No  □ Yes, from ___ to ___

59. Have you ever noticed a swelling of the salivary glands?
   □ No  □ Yes, from ___ to ___
60. Have you ever noticed a stiffness of the skin on the fingers, neck or face?

☐ No  ☐ Yes, from ___ to ___ (Please underline the appropriate option above)

61. Have you ever had fever of unknown origin in the past?

☐ No  ☐ Yes, from ___ to ___
III. Dermatological Anamnesis

62. Have you been diagnosed with skin diseases?

☐ No or unknown
☐ Yes, I know the following (please specify)

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<th>Initial treating diagnostician or institution</th>
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63. Do you remember that there were skin diseases in your family (children, grandchildren, siblings, parents, grandparents)?

☐ No or unknown
☐ Yes, I know the following (please specify)

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<tr>
<th>Family member</th>
<th>Disease (if unknown, please describe the disease)</th>
<th>Date of initial diagnosis</th>
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64. From when to when did you work in which profession? Do you remember any allergies or intolerances (for example, contact allergies with chemicals, detergents, work clothes, etc.)?

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<th>From ___ to ____ (year)</th>
<th>Profession</th>
<th>Anomalies?</th>
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65. If no skin diseases have been diagnosed, have you ever noticed skin problems on your body?

☐ No or unknown (If answered with no, this questionnaire is now finished for you)
☐ Yes (Please mark the skin area where you could ever find a skin condition)

65.1 Number of skin manifestations:
☐ 1-3  ☐ 3-10  ☐ >10

65.2 Arrangement of the skin symptoms:
☐ at one body site  ☐ at several body sites  ☐ generalized all over the body

65.3 Symmetry of the skin symptoms:
☐ symmetrical  ☐ asymmetrical
65.4 Does the skin appearance have a pattern?
- No, the skin condition is random
- Yes, the appearance of the skin has a recognizable pattern

(If yes, try to find an appropriate pattern from the following drawings)

- solitary (a coherent skin condition)
- angular (circular)
- polycyclic (multi-circle)
- garland-like
- grouped (e.g. small bubbles in groups)
- disseminated (distributed randomly)
- cockade like (shooting disc like)
- confluent
65.5 What is the limitation of the skin appearance?
□ sharp □ blurry

65.6 How big is this skin condition?

65.7 What is the color of the skin appearance?

65.8 What is the surface of the skin appearance? (Multiple choice possible)
□ in or on the skin level
□ above the skin level
□ rough
□ smooth
□ shiny
□ scaly
□ crusty
□ rough
□ doughy
□ blister-shaped
□ knot-shaped
□ with cracking of the skin (cracked)
□ dry
□ wet

65.9 Did a skin defect persist after healing of the skin (eg scar, light spot, etc.)?
□ No □ Yes

65.10 Was there a loss of body hair over the areas of the skin appearance?
□ No □ Yes

65.11 Did these skin appearances go with any of the following symptoms? (Multiple choice possible)
□ pain
□ itching
□ loss of sensation
□ other: _______

65.12 Was this skin condition related to medication?
□ No □ Yes, the skin symptoms occurred in the following contexts:
65.13 Course: How long did these skin symptoms persist?
- days
- weeks
- months
- years

66. Are there any other skin changes that have not been asked here or have you noticed any changes in your nails or hair?
- No
- Yes, I have noticed the following skin lesions or changes in nails or hair:

□

□
IV. Appendix with Evaluation

1. The questionnaire covers all important aspects of my medical history.
   - totally agree
   - tend to agree
   - partly agree
   - tend to disagree
   - strongly disagree

2. The questions are formulated comprehensibly.
   - totally agree
   - tend to agree
   - partly agree
   - tend to disagree
   - strongly disagree

3. The questionnaire is...
   - just right
   - rather right
   - partially agree
   - rather too extensive
   - too extensive

This questionnaire is now finished. Thank you for your time.