**For Research Laboratory Use Only**

Subject ID: ________________ PD____ RBD___ Control__ Day sample received M____ D_____ Y_____

*Interactions of Gut Microbiome, Genetic Susceptibility, and Environmental Factors in Parkinson's Disease*

A Research Study Funded by The United States Department of Defense

# GUT MICROBIOME QUESTIONNAIRE

Thank you for participating in this research study. Please complete this form immediately after collecting the stool sample and send it back with the stool sample and the completed Environmental & Family History Questionnaire in the enclosed pre-stamped envelope. If you have any questions, please call 205-934-0371.

Today's date (day of stool sample collection): Month__________ Day________ Year_________

Your Name: ______________________________________________________

Sex: ❐ M ❐ F

Birthdate: Month ______ Day________ Year ________

Phone ________________________________ Email ________________________________

On the **<u>DAY OF STOOL COLLECTION</u>** did you have:

Abdominal pain or discomfort ❐No ❐Yes

Bloating ❐No ❐Yes

Diarrhea ❐No ❐Yes

Excess gas ❐No ❐Yes

Constipation (no bowel movement for 3 days prior to stool collection) ❐No ❐Yes

In this **Bristol Stool Chart**, circle the type of stool that you passed today from which you collected the sample:

| | | |
|---|---|---|
| Type 1 | Separate hard lumps, like nuts hard to pass | |
| Type 2 | Sausage shaped but lumpy | |
| Type 3 | Like sausage but with cracks on its surface | |
| Type 4 | Like sausage or snake, smooth and soft | |
| Type 5 | Soft blobs with clear cut edges (passed easily) | |
| Type 6 | Fluffy pieces with ragged edges, a mushy stool | |
| Type 7 | Watery, no solid pieces | ENTIRELY LIQUID |

How tall are you? Feet_____ Inches________

How much do you weigh? Pounds________

Have you lost more than 10 pounds in the last year? ❒ No ❒ Yes

Have you gained more than 10 pounds in the last year? ❒ No ❒ Yes

In a typical week, how many hours of sleep do you get each night? __________ hours

Do you smoke cigarettes, cigars or a pipe? ❒ No ❒ Yes

Do you drink caffeinated coffee, caffeinated tea, or caffeinated soda? ❒ No ❒ Yes

Do you drink alcohol? ❒ No ❒ Yes

## DIET

How often do you eat **GRAINS** (rice, bread, pasta)?

❒ At least once a day
❒ Few times a week
❒ Few times a month
❒ Less than once a month or never

How often do you eat **POULTRY, BEEF, PORK, SEAFOOD, EGGS?**

❒ At least once a day
❒ Few times a week
❒ Few times a month
❒ Less than once a month or never

How often do you eat **FRUITS or VEGETABLES**?

❒ At least once a day
❒ Few times a week
❒ Few times a month
❒ Less than once a month or never

How often do you eat **NUTS**?

❒ At least once a day
❒ Few times a week
❒ Few times a month
❒ Less than once a month or never

How often do you eat **YOGURT**?

❒ At least once a day
❒ Few times a week
❒ Few times a month
❒ Less than once a month or never

## MEDICAL CONDITIONS

Do you have Parkinson's disease? ❐No ❐Yes

Do you have rapid eye movement sleep behavior disorder (RBD)? ❐No ❐Yes

Are you often constipated (fewer than 3 bowel movements per week occurring frequently)? ❐No ❐Yes

Do have Diarrhea often (once a week or more, type 7 in Bristol stool chart)? ❐No ❐Yes

Do you have Irritable Bowel Syndrome (IBS) or spastic colon? ❐No ❐Yes

Do you have Inflammatory Bowel Disease (IBD)? ❐No ❐Yes

Do you have Small Intestinal Bacterial Overgrowth (SIBO)? ❐No ❐Yes

Have you had an Ulcer in the past three months? ❐No ❐Yes

Do you have Celiac disease? ❐No ❐Yes

Do you have Crohn's disease? ❐No ❐Yes

Do you have Colitis? ❐No ❐Yes

Have you had a cancer of the digestive system in the last 3 months? ❐No ❐Yes

## MEDICATIONS

Are you currently taking antibiotics? ❐ No ❐ Yes

Have you completed a course of antibiotics in the past 3 months? ❐ No ❐ Yes

Do you take laxatives at least once a week? ❐ No ❐ Yes

Do you take drugs for indigestion or reflux at least once a week? ❐ No ❐ Yes

Do you take anti-inflammatory drugs at least once a week? ❐No ❐Yes

Are you currently being treated for cancer with radiation or chemotherapy? ❐ No ❐ Yes

Are you taking blood thinners? ❐ No ❐ Yes

Are you taking cholesterol medication? ❐No ❐Yes

Are you taking blood pressure medication? ❐ No ❐ Yes

Are you taking thyroid medication? ❐ No ❐ Yes

Are you taking medication for asthma or COPD? ❐ No ❐ Yes

Are you taking medication for diabetes, high blood sugar, insulin? ❐ No ❐ Yes

Are you taking pain medication? ❐ No ❐ Yes

Are you taking medication for depression, anxiety, mood? ❐ No ❐ Yes

Are you on birth control pills or estrogen replacement therapy? ❐ No ❐ Yes

Are you taking Antihistamines? ❐ No ❐ Yes

Do you take Probiotic supplements? ❐ No ❐ Yes

Do you take Co-Q 10 supplements? ❐ No ❐ Yes

Do you take a sleep aid to help you fall asleep or stay asleep? ❐ No ❐ Yes

Are you **CURRENTLY** taking any **PARKINSON MEDICATIONS?** ❒No ❒Yes

If no, you can skip the rest of the form.
If yes, check all medications that you are taking (we have given the two names available for each medication).

**Levodopa preparations:**

❒ No ❒ Yes Sinemet or immediate release Carbidopa-Levodopa mg/pill______Number of Pills/day______

❒ No ❒ Yes Sinemet CR or Carbidopa/Levodopa ER mg/pill______Number of Pills/day______

❒ No ❒ Yes Rytary or Carbidopa/levodopa Capsules mg/pill______Number of Pills/day______

❒ No ❒ Yes Duopa or levodopa intestinal gel mg/24 hrs______

❒ No ❒ Yes Stalevo or Carbidopa/levodopa/entacapone mg/pill______Number of Pills/day______

**Dopamine agonist drugs:**

❒ No ❒ Yes Mirapex or Pramipexole immediate release or ER mg/pill______Number of Pills/day______

❒ No ❒ Yes Requip or Ropinirole immediate release or XR mg/pill______Number of Pills/day______

❒ No ❒ Yes Neupro or Rotigotine patch mg/patch_____

❒ No ❒ Yes Apokyn or apomorphine injections or infusion cc/injection_____Number of injections/day_____

**COMT Inhibitors:**

❒ No ❒ Yes Comtan or Entacapone mg/pill_____Number of Pills/day______

❒ No ❒ Yes Tasmar or tolcapone mg/pill______Number of Pills/day______

**MAO Inhibitors:**

❒ No ❒ Yes Azilect or Rasagiline mg/pill______Number of Pills/day______

❒ No ❒ Yes Eldepryl or Deprenyl or Selegiline mg/pill______Number of Pills/day______

❒ No ❒ Yes Xadago or Safinamide mg/pill______Number of Pills/day_____

**Anticholinergic drugs:**

❒ No ❒ Yes Artane or Trihexyphenidyl mg/pill______Number of Pills/day_____

❒ No ❒ Yes Cogentin or Benztropine mg/pill______Number of Pills/day_____

**Other medication for Parkinson:**

❒ No ❒ Yes Symmetrel or Amantadine mg/pill______Number of Pills/day_____

**Other Parkinson medications:**

1. Medication name _______________________ mg/pill______Number of Pills/day_____

2. Medication name________________________ mg/pill______Number of Pills/day_____

3. Medication name________________________ mg/pill______Number of Pills/day_____

**Thank you for completing the questionnaire.**
**Please mail it back with the stool sample and the Environmental & Family History Questionnaire using the pre-stamped envelope. You may drop the envelope at any US postal service box.**