

# SE Checklist V20

In the LAST WEEK, have you experienced or been concerned about each of the following things?  
Check all that apply:

- Irritability
- Agitation
- Hostility
- Irregular heartbeat or palpitations
- Increased heart rate
- Chest pain
- Depressed mood
- Nausea
- Vomiting
- Abdominal pain
- Constipation
- Diarrhea
- Dry mouth
- Indigestion
- Gas or flatulence
- Anxiety
- Skin swelling
- Rash or skin redness (not sunburn)
- Headache
- Dizziness
- Insomnia
- Abnormal dreams
- Sleepwalking
- Other sleep problems
- Other
- None of the above

## Yes, I have experienced or been concerned about ...

	but does not interfere with daily activities	and interferes with some activities	no normal activities are possible
Irritability	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Agitation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hostility	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Irregular heartbeat or palpitations	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Increased heart rate	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chest pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Depressed mood	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Nausea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vomiting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Abdominal pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Constipation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diarrhea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dry mouth	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Indigestion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Gas or flatulence	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anxiety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Skin swelling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rash or skin redness (not sunburn)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Headache	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dizziness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Insomnia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Abnormal dreams	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sleepwalking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other sleep problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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You checked that you have some other concern(s) or problem(s). Please describe all other concerns or problems below:

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This other concern or experience...

(If you listed more than one concern, please respond with the highest level of interference of activities of those listed.)

- does not interfere with daily activities
- interferes with some activities
- makes normal activities impossible