

Patient Name: _____

Date: _____

Instrument - COMPASS 31

1. In the past year, have you ever felt faint, dizzy, "goofy", or had difficulty thinking soon after standing up from a sitting or lying position?

- 1 Yes**
- 2 No (if you marked No, please skip to question 5)**

2. When standing up, how frequently do you get these feelings or symptoms?

- 1 Rarely**
- 2 Occasionally**
- 3 Frequently**
- 4 Almost Always**

3. How would you rate the severity of these feelings or symptoms?

- 1 Mild**
- 2 Moderate**
- 3 Severe**

4. In the past year, have these feelings or symptoms that you have experienced:

- 1 Gotten much worse**
- 2 Gotten somewhat worse**
- 3 Stayed about the same**
- 4 Gotten somewhat better**
- 5 Gotten much better
Completely gone**

5. In the past year, have you ever noticed color changes in your skin, such as red, white, or purple?

- 1 Yes
- 2 No (if you marked No, please skip to question 8)

6. What parts of your body are affected by these color changes? (Check all that apply)

- 1 Hands
- 2 Feet

7. Are these changes in your skin color:

- 1 Getting much worse
- 2 Getting somewhat worse
- 3 Staying about the same
- 4 Getting somewhat better
- 5 Getting much better
- 6 Completely gone

8. In the past 5 years, what changes, if any, have occurred in your general body sweating?

- 1 I sweat much more than I used to
- 2 I sweat somewhat more than I used to
- 3 I haven't noticed any changes in my sweating
- 4 I sweat somewhat less than I used to
- 5 I sweat much less than I used to

9. Do your eyes feel excessively dry?

- 1 Yes
- 2 No

10. Does your mouth feel excessively dry?

- 1 Yes
- 2 No

11. For the symptom of dry eyes or dry mouth that you have had for the longest period of time, is this symptom:

- 1 I have not had any of these symptoms
- 2 Getting much worse
- 3 Getting somewhat worse
- 4 Staying about the same
- 5 Getting somewhat better
- 6 Getting much better
- 7 Completely gone

12. In the past year, have you noticed any changes in how quickly you get full when eating a meal?

- 1 I get full a lot more quickly now than I used to
- 2 I get full more quickly now than I used to
- 3 I haven't noticed any change
- 4 I get full less quickly now than I used to
- 5 I get full a lot less quickly now than I used to

13. In the past year, have you felt excessively full or persistently full (bloated feeling) after a meal?

- 1 Never
- 2 Sometimes

3 A lot of the time

14. In the past year, have you vomited after a meal?

- 1 Never
- 2 Sometimes
- 3 A lot of the time

15. In the past year, have you had a cramping or colicky abdominal pain?

- 1 Never
- 2 Sometimes
- 3 A lot of the time

16. In the past year, have you had any bouts of diarrhea?

- 1 Yes
- 2 No (if you marked No, please skip to question 20)

17. How frequently does this occur?

- 1 Rarely
- 2 Occasionally
- 3 Frequently _____ times per month
- 4 Constantly

18. How severe are these bouts of diarrhea?

- 1 Mild
- 2 Moderate
- 3 Severe

19. Are your bouts of diarrhea getting:

- 1 Much worse
- 2 Somewhat worse
- 3 Staying the same
- 4 Somewhat better
- 5 Much better
- 6 Completely gone

20. In the past year, have you been constipated?

- 1 Yes
- 2 No (if you marked No, please skip to question 24)

21. How frequently are you constipated?

- 1 Rarely
- 2 Occasionally
- 3 Frequently _____ times per month
- 4 Constantly

22. How severe are these episodes of constipation?

- 1 Mild
- 2 Moderate
- 3 Severe

23. Is your constipation getting:

- 1 Much worse
- 2 Somewhat worse
- 3 Staying the same
- 4 Somewhat better

- 5 Much better
- 6 Completely gone

24. In the past year, have you ever lost control of your bladder function?

- 1 Never
- 2 Occasionally
- 3 Frequently _____ times per month
- 4 Constantly

25. In the past year, have you had difficulty passing urine?

- 1 Never
- 2 Occasionally
- 3 Frequently _____ times per month
- 4 Constantly

26. In the past year, have you had trouble completely emptying your bladder?

- 1 Never
- 2 Occasionally
- 3 Frequently _____ times per month
- 4 Constantly

27. In the past year, without sunglasses or tinted glasses, has bright light bothered your eyes?

- 1 Never (if you marked Never, please skip to question 29)
- 2 Occasionally
- 3 Frequently
- 4 Constantly

28. How severe is this sensitivity to bright light?

- 1 Mild
- 2 Moderate
- 3 Severe

29. In the past year, have you had trouble focusing your eyes?

- 1 Never (if you marked Never, please skip to question 31)
- 2 Occasionally
- 3 Frequently
- 4 Constantly

30. How severe is this focusing problem?

- 1 Mild
- 2 Moderate
- 3 Severe

31. Is the most troublesome symptom with your eyes (i.e. sensitivity to bright light or trouble focusing) getting:

- 1 I have not had any of these symptoms
- 2 Much worse
- 3 Somewhat worse
- 4 Staying about the same
- 5 Somewhat better
- 6 Much better
- 7 Completely gone