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PPMI

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SUBJECT ID VISIT NO
 INITIALS SITE NO VISIT DATE
 MM DD YYYY

A. Source of Information: 1 = Patient, 2 = Caregiver, 3 = Patient and caregiver A.

SCOPA-AUT

By means of this questionnaire, we would like to find out to what extent in the past month you have had problems with various bodily functions, such as difficulty passing urine, or excessive sweating. Answer the questions by placing a cross in the box which best reflects your situation. If you wish to change an answer, fill in the 'wrong' box and place a cross in the correct one. If you have used medication in the past month in relation to one or more of the problems mentioned, then the question refers to how you were while taking this medication. You can note the use of medication on the last page.

1. In the past month have you had difficulty swallowing or have you choked?
 never sometimes regularly often
2. In the past month, has saliva dribbled out of your mouth?
 never sometimes regularly often
3. In the past month, has food ever become stuck in your throat?
 never sometimes regularly often
4. In the past month, did you ever have the feeling during a meal that you were full very quickly?
 never sometimes regularly often
5. *Constipation is a blockage of the bowel, a condition in which someone has a bowel movement twice a week or less.*
 In the past month, have you had problems with constipation?
 never sometimes regularly often
6. In the past month, did you have to strain hard to pass stools?
 never sometimes regularly often

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7. In the past month, have you had involuntary loss of stools?

never

sometimes

regularly

often

Questions 8 to 13 deal with problems with passing urine. If you use a catheter you can indicate this by placing a cross in the box "use catheter".

8. In the past month, have you had difficulty retaining urine?

never

sometimes

regularly

often

*use
catheter*

9. In the past month, have you had involuntary loss of urine?

never

sometimes

regularly

often

*use
catheter*

10. In the past month, have you had the feeling that after passing urine your bladder was not completely empty?

never

sometimes

regularly

often

*use
catheter*

11. In the past month, has the stream of urine been weak?

never

sometimes

regularly

often

*use
catheter*

12. In the past month, have you had to pass urine again within 2 hours of the previous time?

never

sometimes

regularly

often

*use
catheter*

 13. In the past month, have you had to pass urine at night?

never

sometimes

regularly

often

*use
catheter*

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14. In the past month, when standing up have you had the feeling of either becoming light-headed, or no longer being able to see properly, or no longer being able to think clearly?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
never	sometimes	regularly	often

15. In the past month, did you become light-headed after standing for some time?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
never	sometimes	regularly	often

16. Have you fainted in the past 6 months?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
never	sometimes	regularly	often

17. In the past month, have you ever perspired excessively during the day?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
never	sometimes	regularly	often

18. In the past month, have you ever perspired excessively during the night?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
never	sometimes	regularly	often

19. In the past month, have your eyes ever been over-sensitive to bright light?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
never	sometimes	regularly	often

20. In the past month, how often have you had trouble tolerating cold?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
never	sometimes	regularly	often

21. In the past month, how often have you had trouble tolerating heat?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
never	sometimes	regularly	often

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The following questions are about sexuality. Although we are aware that sexuality is a highly intimate subject, we would still like you to answer these questions. For the questions on sexual activity, consider every form of sexual contact with a partner or masturbation (self-gratification). An extra response option has been added to these questions. Here you can indicate that the situation described has not been applicable to you in the past month, for example because you have not been sexually active. Questions 22 and 23 are intended specifically for men, 24 and 25 for women.

The following 3 questions are only for men

22. In the past month, have you been impotent (unable to have or maintain an erection)?

never

sometimes

regularly

often

not applicable

23. In the past month, how often have you been unable to ejaculate?

never

sometimes

regularly

often

not applicable

23a. In the past month, have you taken medication for an erection disorder? (If so, which medication?)

no

yes: _____

Proceed with question 26

The following 2 questions are only for women

24. In the past month, was your vagina too dry during sexual activity?

never

sometimes

regularly

often

not applicable

25. In the past month, have you had difficulty reaching an orgasm?

never

sometimes

regularly

often

not applicable

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The following questions are for everyone

26. In the past month, have you used medication for:

- | | | | |
|---|--------------------------|--------------------------|------------------|
| a. constipation? | <input type="checkbox"/> | <input type="checkbox"/> | no
yes: _____ |
| b. urinary problems? | <input type="checkbox"/> | <input type="checkbox"/> | no
yes: _____ |
| c. blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> | no
yes: _____ |
| d. other symptoms
<i>(not symptoms related to Parkinson's disease)</i> | <input type="checkbox"/> | <input type="checkbox"/> | no
yes: _____ |

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Visser M, Marinus J, Stiggelbout AM, van Hilten JJ. Assessment of autonomic dysfunction in Parkinson's disease: The SCOPA-AUT. *Mov Disord.* 2004;19:1306-12.

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