Appendix 1: Patient Questionnaire

☐ **Baseline Information** ☐ **Follow-up Information**

Patients Initials: _____ Patient Phone Number: _____ Date: _____
Diagnosis requiring domperidone treatment: _____
DOB: _____ Age: _____

Ethnicity: ☐ White ☐ Hispanic or Latino ☐ Black or African American ☐ Native American or American Indian
☐ Asian/ Pacific Islander ☐Other: _____

Height: _____ Weight: _____ BMI: _____

Please state your gender: ☐ Female ☐ Male ☐ Prefer not to answer

Points of Interest to capture at visits:

1. What is your current dose of domperidone? _____
   What is the highest dose of domperidone you have taken? _____
   How long have you been taking domperidone? _____ Years _____Months

2. The major symptoms for seeking of domperidone are/were: (select all that apply)
   a) Nausea b) Vomiting c) Bloating d) Acid Reflux
   e) Unable to finish normal sized meals f) other (If other please explain :_____)

3. If diagnosed with diabetes please state which type:
   a) Type 1 diabetes b) Type 2 diabetes c) Do not have diabetes

   3a. If applicable, how long have you been diagnosed with diabetes? _____ Years _____Months
   3b. If diagnosed with diabetes please indicate the most recent blood sugar reading: _____
   The most recent **HbA1C** is: _____

4. If vomiting is present how soon **after** a meal does it occur? (if vomiting is unrelated to meals select **choice A**)
   a) Unrelated to meals b) 15 to 45 minutes c) 45 minutes to an hour d) More than 1 hour

5. If nausea is present, is it before or after meals?
   a) Before meals b) After meals
   If nauseated, how soon before or after a meal does it occur?
   a) Within 15 minutes b) 15 to 45 minutes c) 45 minutes to an hour d) More than 1 hour

Other symptoms/signs? (If yes, please indicate the severity and the frequency, by selecting the appropriate Number)

Symptom	Severity		Frequency	
1.Abdominal discomfort/ pain	1.	**Severity Scale**	1.	**Frequency Scale**
2.Unable to finish normal size meals	2.	**0=absent**	2.	**0=absent**
3. Bloating after meals	3.		3.	
4.Nausea	4.	**1=mild**	4.	**1=rare (1 time/wk.)**
5. Vomiting	5.		5.	
6. Constipation	6.	**2=moderate**	6.	**2=occasional (2-3 times/wk.)**
7. Diarrhea	7.		7.	
8. Heart palpitations	8.	**3=severe**	8.	**3=Frequent (4-6 times/wk.)**
9. Nipple tenderness	9.		9.	
10. Breast enlargement	10	**4=extremely severe**	10.	**4=Extremely frequent (7 or more times/wk.)**
11. Nipple discharge	11.		11.	
12. Chest pain	12		12.	
13. Muscle spasms	13.		13.	
14. Restlessness	14.		14.	

Please answer the following as either yes or no (If Applicable)

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Question	YES	NO	Specifics?
Were there hospitalizations **since taking domperidone** because of the stomach problem?			
If patient is female, has she experienced irregular periods since taking domperidone?			
Did patient **gain** significant weight since taking domperidone?			
Did patient **lose** significant weight since taking domperidone (unintentionally)?			
Has an ECG been taken during this visit?			

Since starting domperidone, approximately how frequently or how many ECG's have been taken? _____

Did patient have heart related problems since starting domperidone? _____

Was there a change in symptoms requiring domperidone: → **Worse** **Better** **No Change**

Please indicate on the number line below how much better, the same or worse is primary symptom addressed with domperidone: