

Questionnaire

Patient ID:

Gender & Date of Birth

Which gender is the participant? (this must be the same as stated on the enrolment form):

- ☐ Male
- ☐ Female
- ☐ Transgender male
- ☐ Transgender female
- ☐ Other
- ☐ Unknown

Date of Birth:

Has patient been seen for Visit 2?

- ☐ Yes
- ☐ No

Please specify why:

Stool

Date of defecation for current stool sample:

Stool sample receive date at clinic:

Stool consistency as reported by participant based on the Bristol Stool Form Scale for current sample:

View description:

<https://www.mdcalc.com/bristol-stool-form-scale>Note: Clicking the link will open a new window, allowing you to continue entering data.

- ☐ Type 1
- ☐ Type 2
- ☐ Type 3
- ☐ Type 4
- ☐ Type 5
- ☐ Type 6
- ☐ Type 7

Time of defecation for current stool sample:

(e.g., 12:30)

Average stool consistency (i.e., most frequent type of stool) based on the Bristol Stool Form Scale in the last 14 days:

View description:

<https://www.mdcalc.com/bristol-stool-form-scale>Note: Clicking the link will open a new window, allowing you to continue entering data.

- ☐ Type 1
- ☐ Type 2
- ☐ Type 3
- ☐ Type 4
- ☐ Type 5
- ☐ Type 6
- ☐ Type 7

Average stool frequency (times per day) within last 14 days:

- ☐ Less than every 3rd day
☐ Every 2nd to every 3rd day
☐ 1-3 x daily
☐ 4-5 x daily
☐ > 5 x daily
☐ Unknown

Diet, vitamins, probiotics and alcohol

Please tick the box that best represents the participant's current diet classification: (initiation of diet at least two weeks prior to visit)

Omnivore: both plant- and animal-based diet

☐

Pescatarian: plant- and fish/seafood-based diet (i.e. a person who adds fish and seafood to a vegetarian diet)

☐

Vegetarian: plant-based diet including dairy products and eggs

☐

Vegan: solely plant-based diet (i.e. no animal products or by-products)

☐

Does the participant have a lactose-free diet: no consumption of products with lactose?

- ☐ Yes
☐ No
☐ Unknown

Does the participant have a gluten-free diet: no consumption of products with gluten?

- ☐ Yes
☐ No
☐ Unknown

How many days per week do you eat red meat?

- ☐ 0
☐ 1-3
☐ 4-5
☐ 6-7
☐ Unknown

What is the average number of portions of fruit and/or vegetable that you consume per day (e.g., one bell pepper, a handful of peas or one apple)?

- ☐ 0
☐ 1-2
☐ 3-5
☐ > 5
☐ Unknown

What is the average number of portions of dairy/milk that you consume per day (e.g., one glass or cup of yogurt or milk (200 ml) or two slices (60 g) of hard cheese or 2 spoons (25 g) of soft cheese)?

- ☐ 0
☐ 1-2
☐ 3-5
☐ > 5
☐ Unknown

What is the average number of portions of fiber/whole grains that you consume per day (e.g., one slice wholegrain bread, ½ cup brown rice, wholegrain pasta or cereal)?

- ☐ 0
☐ 1-2
☐ 3-5
☐ > 5
☐ Unknown

Document including the most common sources of fibre:

Note: Clicking the link will open a new window, allowing you to continue entering data.

[Attachment: "Food List_fibres.pdf"]

Have you taken a multi-vitamin tablet regularly for the last month:

- ☐ No
☐ Yes
☐ Unknown

Have you taken a vitamin D tablet regularly for the last month:

- ☐ No
☐ Yes
☐ Unknown

Have you taken a vitamin B tablet regularly for the last month:

- ☐ No
☐ Yes
☐ Unknown

Have you consumed probiotics:

Examples of probiotics:

- Yogurt and yogurt-like products (Kefir, fermented milk, etc.)
- Kombucha
- Probiotic supplements

- ☐ Daily or 4-6 times a week within the last week
☐ Daily or 4-6 times a week within the last month
☐ 1-3 times a week within the last week
☐ 1-3 times a week within the last month
☐ None
☐ Unknown

Probiotics, type:

☐ Yogurt and yogurt-like products (Kefir, fermented milk, etc.)

☐ Kombucha

☐ Probiotic supplements

If probiotic supplements, please specify:

What is the average number of alcoholic beverages you have had per week (one alcoholic beverage is equal to e.g., one beer (250 mL), glass of wine (110 mL), or spirit (30 mL)):

Treatment

Please find the document 'List of Antibiotics, Antifungal and Anti-inflammatory Medications' for download at the end of the eCRF in REDCap.

Antibiotics

Have you taken antibiotics within the last three months (excluding topical treatment (e.g., applied to the skin)):

- ☐ No
☐ Yes
☐ Unknown

Please report all antibiotics taken within three months from stool sample collection
 If treatment is ongoing, please leave stop date blank

Antibiotic (1):	
Start date Antibiotic (1):	
Stop date Antibiotic (1):	
Antibiotic (2):	
Start date Antibiotic (2):	
Stop date Antibiotic (2):	
Antibiotic (3):	
Start date Antibiotic (3):	
Stop date Antibiotic (3):	
Antibiotic (4):	
Start date Antibiotic (4):	
Stop date Antibiotic (4):	
Antibiotic (5):	
Start date Antibiotic (5):	
Stop date Antibiotic (5):	
Antibiotic (6):	
Start date Antibiotic (6):	
Stop date Antibiotic (6):	

Antibiotic (7):	
Start date Antibiotic (7):	
Stop date Antibiotic (7):	
Antibiotic (8):	
Start date Antibiotic (8):	
Stop date Antibiotic (8):	
Antibiotic (9):	
Start date Antibiotic (9):	
Stop date Antibiotic (9):	
Antibiotic (10):	
Start date Antibiotic (10):	
Stop date Antibiotic (10):	
Antibiotic (11):	
Start date Antibiotic (11):	
Stop date Antibiotic (11):	
Antibiotic (12):	
Start date Antibiotic (12):	
Stop date Antibiotic (12):	

Antibiotic (13):

Start date Antibiotic (13):

Stop date Antibiotic (13):

Antibiotic (14):

Start date Antibiotic (14):

Stop date Antibiotic (14):

Antibiotic (15):

Start date Antibiotic (15):

Stop date Antibiotic (15):

Antifungal Medication

Have you taken antifungal medication within the last three months (excluding topical treatment (e.g., applied to the skin)):

☐ No

☐ Yes

☐ Unknown

Please report all antifungal medications taken within three months from stool sample collection date.

If the treatment is ongoing, please leave stop date blank

Antifungal (1):

Start date Antifungal (1):

Stop date Antifungal (1):

Antifungal (2):

Start date Antifungal (2):

Stop date Antifungal (2):

Antifungal (3):	
Start date Antifungal (3):	
Stop date Antifungal (3):	
Antifungal (4):	
Start date Antifungal (4):	
Stop date Antifungal (4):	
Antifungal (5):	
Start date Antifungal (5):	
Stop date Antifungal (5):	
Antifungal (6):	
Start date Antifungal (6):	
Stop date Antifungal (6):	
Antifungal (7):	
Start date Antifungal (7):	
Stop date Antifungal (7):	
Antifungal (8):	
Start date Antifungal (8):	
Stop date Antifungal (8):	

Antifungal (9):

Start date Antifungal (9):

Stop date Antifungal (9):

Antifungal (10):

Start date Antifungal (10):

Stop date Antifungal (10):

Anti-inflammatory Medication

Have you taken anti-inflammatory medication (e.g.,
ibuprofen, aspirin, other NSAIDs) within the last
three months (excluding topical treatment (e.g.,
applied to the skin)):

☐ No

☐ Yes

☐ Unknown

Please report all anti-inflammatory medication taken within three months from stool sample collection date

If treatment is ongoing, please leave stop date blank

Anti-inflammatory (1):

Start date Anti-inflammatory (1):

Stop date Anti-inflammatory (1):

Anti-inflammatory (2):

Start date Anti-inflammatory (2):

Stop date Anti-inflammatory (2):

Anti-inflammatory (3):

Start date Anti-inflammatory (3):

Stop date Anti-inflammatory (3):

Anti-inflammatory (4):	
Start date Anti-inflammatory (4):	
Stop date Anti-inflammatory (4):	
Anti-inflammatory (5):	
Start date Anti-inflammatory (5):	
Stop date Anti-inflammatory (5):	
Anti-inflammatory (6):	
Start date Anti-inflammatory (6):	
Stop date Anti-inflammatory (6):	
Anti-inflammatory (7):	
Start date Anti-inflammatory (7):	
Stop date Anti-inflammatory (7):	
Anti-inflammatory (8):	
Start date Anti-inflammatory (8):	
Stop date Anti-inflammatory (8):	
Anti-inflammatory (9):	
Start date Anti-inflammatory (9):	
Stop date Anti-inflammatory (9):	

Anti-inflammatory (10):

Start date Anti-inflammatory (10):

Stop date Anti-inflammatory (10):

Proton Pump Inhibitors

Hormone Treatment

Have you taken oral hormonal birth control or post-menopausal hormone replacement therapy within the last month:

- ☐ No or Not Relevant
☐ Yes
☐ Unknown

Date for latest start:

Date for latest stop:

(if the treatment is ongoing, please leave stop date blank)

Have you taken transgender hormone replacement within the last month?

- ☐ No or Not Relevant
☐ Yes
☐ Unknown

Date for latest start:

Date for latest stop:

(if the treatment is ongoing, please leave stop date blank)

Have you received oestrogen treatment within the last month?

- ☐ No or Not Relevant
☐ Yes
☐ Unknown

Date for latest start:

Date for latest stop:

(if the treatment is ongoing, please leave stop date blank)

Have you received testosterone treatment within the last month?

- ☐ No or Not Relevant
☐ Yes
☐ Unknown

Date for latest start:

Date for latest stop:

(if the treatment is ongoing, please leave stop date blank)

Sex Life

Do you receive anal sex:

- ☐ No
☐ Yes
☐ Unknown

Have you received anal sex in the last 3 days?

- ☐ No
☐ Yes
☐ Unknown

Diseases and surgery

For Visit 2, ask the patient if diseases and surgery have occurred since last visit

Have you ever been clinically diagnosed with specific gastrointestinal disease (ulcerative colitis, Crohn's, irritable bowel syndrome, chronic constipation, chronic diarrhoea, etc.):

- ☐ No
☐ Yes
☐ Unknown

Please note that anal haemorrhoids or condylomas, or upper gastric diseases are not considered gastrointestinal diseases
(For Visit 2, ask the patient if it has occurred since last visit)

Chronic constipation: infrequent bowel movements or difficult passage of stools that persists for several weeks or longer. Constipation is generally described as having fewer than three bowel movements a week.

Chronic diarrhea: loose, watery stools three or more times a day for more than four weeks.

Have you had major surgery of the gastrointestinal tract (exception of cholecystectomy and appendectomy) in the past five years:
(For Visit 2, ask the patient if it has occurred since last visit)

- ☐ No
☐ Yes
☐ Unknown

Have you had any major bowel resection (surgical removal of part of the colon or rectum) at any time:

- ☐ No
☐ Yes
☐ Unknown

(For Visit 2, ask the patient if it has occurred since last visit)

Date of latest bowel resection (surgical removal of part of the colon or rectum):

Do you have gluten intolerance:

- ☐ No
☐ Yes
☐ Unknown

(For Visit 2, ask the patient if it has occurred since last visit)

Diagnosis type of gluten intolerance:

- ☐ Diagnosed by a clinician
☐ Self-reported
☐ Unknown

When was the gluten intolerance diagnosed/ reported:

Do you have lactose intolerance:

- ☐ No
☐ Yes
☐ Unknown

(For Visit 2, ask the patient if it has occurred since last visit)

Type of the lactose intolerance diagnosis:

- ☐ Diagnosed by a clinician
☐ Self-reported
☐ Unknown

When was the lactose intolerance diagnosed/ reported:

Lifestyle and Infant History

Have you traveled outside of current resident country within the last three months:

- ☐ No
☐ Yes
☐ Unknown

Have you had a pet with fur or feathers living in household within the last month:

- ☐ No
☐ Yes
☐ Unknown

What is your average exercise per week (in hours) the last month:

Examples of exercise:

- Aerobic: walking, running, swimming, cycling

- Muscle-strengthening: strength or resistance training

- Flexibility: stretching, yoga, tai chi

Were you primarily breastfed as an infant?

- ☐ No
☐ Yes
☐ Unknown

What was the method in which you were born?

- ☐ Vaginally
☐ Cesarean section
☐ Unknown