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Name \_\_\_\_\_ Date \_\_\_\_\_

E-mail \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

What country do you live in? \_\_\_\_\_

Please describe briefly (in one sentence) what your main problem(s) are (you will be able to describe things at length later – towards the end of the questionnaire):

\_\_\_\_\_  
\_\_\_\_\_

1. Do you have any drug allergies \_\_\_\_\_
2. Are you fatigued and when did this start \_\_\_\_\_
3. How much has fatigue decreased your function \_\_\_\_\_
4. Did symptoms begin: \_\_\_\_ suddenly \_\_\_\_ gradually
5. What symptoms presented at onset \_\_\_\_\_

5a. Have you been diagnosed in the past with:

_____ Fibromyalgia	Date _____	Physician Name _____
_____ Chronic Fatigue Syndrome	Date _____	Physician Name _____
_____ Lyme disease	Date _____	Physician Name _____

6. What stresses were occurring in your life when the disease began \_\_\_\_\_

7. How many children do you have \_\_\_\_\_ Ages & names \_\_\_\_\_

8. Are you: married, single, separated, divorced, widowed (circle one)

9. How many hours a week were you working (including commute) at the onset of your illness \_\_\_\_\_;

How many hours spent weekly on your children's care of care of your family at onset \_\_\_\_\_

9a. How many hours now, work/commute? \_\_\_\_\_ hrs/wk; Children and/or family care \_\_\_\_\_ hrs/wk

10. Occupation \_\_\_\_\_

11. Do you have family members with Fibromyalgia/Chronic Fatigue Syndrome or Lyme \_\_\_\_ Yes \_\_\_\_ No

11a. If so: What disease, family member and age \_\_\_\_\_

12. How old are you? \_\_\_\_\_ Date of birth? \_\_\_\_\_ Female \_\_\_\_\_ Male \_\_\_\_\_

13. How many doctors have you seen for your symptoms \_\_\_\_\_

14. How many years have you been in the diagnosis process \_\_\_\_\_

**15. check any of these that you have or have had:**

**Onset At:**

- |   |                    |
|---|--------------------|
| _____ Stroke(s)                                 | Approx. year _____ |
| _____ Multiple Sclerosis                        | Approx. year _____ |
| _____ Neuropathies – If so, what type _____     | Approx. year _____ |
| _____ Glaucoma                                  | Approx. year _____ |
| _____ Cataracts                                 | Approx. year _____ |
| _____ Lupus                                     | Approx. year _____ |
| _____ Rheumatoid Arthritis                      | Approx. year _____ |
| _____ Osteo Arthritis (“wear & tear” arthritis) | Approx. year _____ |
| _____ Scleroderma                               | Approx. year _____ |

\_\_\_\_\_ **Other Rheumatoid Diseases**

List them:

- \_\_\_\_\_ Approx. year \_\_\_\_\_  
\_\_\_\_\_ Approx. year \_\_\_\_\_  
\_\_\_\_\_ Approx. year \_\_\_\_\_

\_\_\_\_\_ Phlebitis and/or Pulmonary Embolus Approx. year \_\_\_\_\_

If yes, did it go to your lungs Yes \_\_\_\_\_ No \_\_\_\_\_ (i.e., Pulmonary Emolus)

\_\_\_\_\_ **Angina or heart attack (Myocardial Infarction)**

\_\_\_\_\_ Angina; \_\_\_\_\_ Heart attack; \_\_\_\_\_ Both

1) Was this confirmed by -

- \_\_\_\_\_ EKG and/or  
\_\_\_\_\_ Exercise stress test and/or  
\_\_\_\_\_ Heart catheterization

2) Did you have: \_\_\_\_\_ Angioplasty and/or Bypass \_\_\_\_\_ If so, when? \_\_\_\_\_

\_\_\_\_\_ Mitral Valve Prolapse

\_\_\_\_\_ Heart valve disease? Which Disease \_\_\_\_\_

\_\_\_\_\_ **Are you on blood thinners**

If so, check which one and fill in dose:

- \_\_\_\_\_ Coumadin/Warfarin Dose \_\_\_\_\_ mg per day  
\_\_\_\_\_ Heparin Dose \_\_\_\_\_ mg per day  
\_\_\_\_\_ Aspirin Dose \_\_\_\_\_ mg per day  
\_\_\_\_\_ Other Dose \_\_\_\_\_ mg per day

\_\_\_\_\_ Diagnosis of abnormal heart rhythm(s)? Type \_\_\_\_\_

\_\_\_\_\_ **Cancer? (check all that apply):**

\_\_\_\_\_ **Breast;** date of diagnosis \_\_\_\_\_

If yes – Metastatic/Nonmetastatic \_\_\_\_\_, to where \_\_\_\_\_

Did you have (check all that apply):

\_\_\_\_\_ Surgery; \_\_\_\_\_ Radiation Therapy; \_\_\_\_\_ chemotherapy;

Other treatment? What types \_\_\_\_\_

Is it active or without recurrence \_\_\_\_\_

\_\_\_\_\_ **Prostate (males only)**; date of diagnosis \_\_\_\_\_  
If yes – Metastatic/Nonmetastatic \_\_\_\_\_, to where \_\_\_\_\_  
Did you have (check all that apply):  
\_\_\_\_\_ Surgery; \_\_\_\_\_ Radiation Therapy; \_\_\_\_\_ chemotherapy;  
Other treatment? What types \_\_\_\_\_  
Is it active or without recurrence \_\_\_\_\_

\_\_\_\_\_ **Uterine (female only)**; date of diagnosis \_\_\_\_\_  
If yes – Metastatic/Nonmetastatic \_\_\_\_\_, to where \_\_\_\_\_  
Did you have (check all that apply):  
\_\_\_\_\_ Surgery; \_\_\_\_\_ Radiation Therapy; \_\_\_\_\_ chemotherapy;  
Other treatment? What types \_\_\_\_\_  
Is it active or without recurrence \_\_\_\_\_

\_\_\_\_\_ **Ovarian (female only)**; date of diagnosis \_\_\_\_\_  
If yes – Metastatic/Nonmetastatic \_\_\_\_\_, to where \_\_\_\_\_  
Did you have (check all that apply):  
\_\_\_\_\_ Surgery; \_\_\_\_\_ Radiation Therapy; \_\_\_\_\_ chemotherapy;  
Other treatment? What types \_\_\_\_\_  
Is it active or without recurrence \_\_\_\_\_

\_\_\_\_\_ **Other types?** Which? \_\_\_\_\_ Date of diagnosis \_\_\_\_\_  
If yes – Metastatic/Nonmetastatic \_\_\_\_\_, to where \_\_\_\_\_  
Did you have (check all that apply):  
\_\_\_\_\_ Surgery; \_\_\_\_\_ Radiation Therapy; \_\_\_\_\_ chemotherapy;  
Other treatment? What types \_\_\_\_\_  
Is it active or without recurrence \_\_\_\_\_  
Is there still evidence of the cancer being present \_\_\_\_\_  
Has it spread from its original site? \_\_\_\_\_; If yes, to where \_\_\_\_\_

- \_\_\_\_\_ Emphysema
- \_\_\_\_\_ Hypertension - High blood pressure
- \_\_\_\_\_ Asthma
- \_\_\_\_\_ Stomach Ulcers
- \_\_\_\_\_ Spastic Colon or Irritable Bowel Syndrome
- \_\_\_\_\_ Crohn's Disease or Ulcerative colitis – If so, which? \_\_\_\_\_
- \_\_\_\_\_ AIDS
- \_\_\_\_\_ Polio
- \_\_\_\_\_ Tuberculosis
- \_\_\_\_\_ Other chronic infections? Type(s) \_\_\_\_\_
- \_\_\_\_\_ Reflex Sympathetic Dystrophy (RCPS) – Which extremity? \_\_\_\_\_
- \_\_\_\_\_ Recurrent Prostatitis – Has a bacterial culture ever been positive? \_\_\_\_\_
- \_\_\_\_\_ Prostate enlargement
- \_\_\_\_\_ Kidney stones
- \_\_\_\_\_ Active disc Disease (e.g., sciatica)
- \_\_\_\_\_ Kidney failure
- \_\_\_\_\_ Other kidney problems? Describe \_\_\_\_\_

\_\_\_\_\_ **Hepatitis (check all that apply):**

- \_\_\_\_\_ Viral?    \_\_\_\_\_ Hepatitis A
- \_\_\_\_\_ Hepatitis B
- \_\_\_\_\_ Hepatitis C
- \_\_\_\_\_ With infectious Mono

\_\_\_\_\_ Any toxic chemical exposures? If yes, list what exposures and when: \_\_\_\_\_

- \_\_\_\_\_ Lupus
- \_\_\_\_\_ Alcoholic
- \_\_\_\_\_ Other types of Hepatitis? Which \_\_\_\_\_
- \_\_\_\_\_ Unknown cause

Are you using herbs \_\_\_\_\_ List: \_\_\_\_\_

- \_\_\_\_\_ Do you have Cirrhosis    \_\_\_\_\_ I don't know.
- \_\_\_\_\_ Have you had a liver biopsy
- \_\_\_\_\_ Have you had a blood test to check for high iron levels

\_\_\_\_\_ **Diabetes (Circle one if you know)    Type 1    Type 2**

- \_\_\_\_\_ Juvenile onset
- \_\_\_\_\_ Adult onset
- \_\_\_\_\_ Are you taking tablets of Niacin containing over 1000mg per day

\_\_\_\_\_ **Pancreatitis**

If yes, from

- \_\_\_\_\_ Gallstones
- \_\_\_\_\_ Alcohol
- \_\_\_\_\_ Other known cause (list) \_\_\_\_\_
- \_\_\_\_\_ Unknown cause

16. Have you had any other operations? Please list them:

- Year (approx) \_\_\_\_\_ Type of surgery \_\_\_\_\_
- Year (approx) \_\_\_\_\_ Type of surgery \_\_\_\_\_
- Year (approx) \_\_\_\_\_ Type of surgery \_\_\_\_\_

17. Have you had any other hospitalizations? Please list them:

- Year (approx) \_\_\_\_\_ Reason \_\_\_\_\_
- Year (approx) \_\_\_\_\_ Reason \_\_\_\_\_
- Year (approx) \_\_\_\_\_ Reason \_\_\_\_\_

18. What other diagnoses do you have \_\_\_\_\_

19. What medications are you allergic to \_\_\_\_\_

20. Please list anything else you are allergic or sensitive to \_\_\_\_\_

20. Does your insurance pay for medications \_\_\_\_\_ yes;    \_\_\_\_\_ no

If yes: what % \_\_\_\_\_; is there a co-pay \_\_\_\_\_; is there a limit per year: \_\_\_\_\_

Please check any of these treatments you are taking or have taken (Rx means by prescription only):

Treatment	Check if you are currently taking	Did you take in the past then stop	Give the reason Med. discontinued	Dose you are currently taking
Rx – Elavil (Amitriptyline)	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day
Rx – Flexeril (Cyclobenzaprine)	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day
Rx – Desyrel (Trazodone)	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day
Rx – Ambien (Zolpidem)	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day
Rx – Xanax (Aprazolam)	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day
Rx – Klonopin (Clonazepam)	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day
Rx – Soma (Carisprodol)	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day
Rx – Armour Thyroid	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day
Rx – Synthroid	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day
Rx – Cortef	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day
Rx – Florinef (Fludrocortisone)	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day
Rx – Oxytocin ___ Tablets ___ Injection ___ Other	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day
Rx – Natural Estrogen Replacement Brand Name _____	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day
Rx – Birth control pills Brand Name _____	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day
Rx – Natural Progesterone	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day
Rx – Testosterone Brand Name _____	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day
Rx – Valtrex (Valacyclovir)	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day
Rx – Famvir (Famcyclovir)	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day
Rx – Zovirax (Acyclovir)	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day
Rx – Nystatin	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day
Rx – Sporanox (Itraconazole)	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day
Rx – Flagyl	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day

<b>Rx – Yodoxin (Iodoquinol)</b>	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day
<b>Rx – Doxycycline (Tetracycline)</b>	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day
<b>Rx – Nitroglycerin</b>	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day
<b>Rx – Cipro (Ciprofloxacin)</b>	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day
<b>Rx – Zoloft (Sertraline)</b>	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day
<b>Rx – Paxil (Paroxetine)</b>	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day
<b>Rx – Prozac (Fluoxetine)</b>	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day
<b>Rx – Effexor (Venlafaxine)</b>	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day
<b>Rx – Serzone (Nefazodone)</b>	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day
<b>Rx – Wellbutrin (Bupropion)</b>	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day
<b>Rx – Parlodel (Bromocriptine)</b>	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day
<b>Rx – Baclofen</b>	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day
<b>Rx – Neurontin (Gabapentin)</b>	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day
<b>Calcium</b>	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day
<b>Chromagen (iron)</b>	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day
<b>DHEA</b>	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day
<b>Thiamine Pyrophosphate</b>	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day
<b>Creatine Monohydrate</b>	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day
<b>B-Complex</b>	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day
<b>Natrol – “My Favorite Multiple – Take One”</b>	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day
<b>Fibrocare (or other Magnesium/Malic Acid)</b>	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day
<b>Echinacea</b>	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day
<b>Monolaurin</b>	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day
<b>Vitamin B12 ___ injections ___ sublingual</b>	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day

<b>Acetyl-L-Carnitine</b>	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day
<b>Artemesia Annu</b>	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day
<b>Tricyclin</b>	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day
<b>Colostrum</b>	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day
<b>Rhus Tox</b>	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day
<b>Co Enzyme Q10</b>	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day
<b>Lysine</b>	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day
<b>Magnesium Potassium Aspartate</b>	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day
<b>NADH</b>	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day
<b>My-B-Tabs</b>	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day
<b>MSM (sulfur – methyl sulfonyl methane)</b>	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day
<b>St. John's Wort</b>	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day
<b>Ginkgo Biloba</b>	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day
<b>Ginger</b>	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't help <input type="checkbox"/> Don't know if it helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too Expensive	___ mg; ___ x a day

21. What other treatment(s) **are** you on?

Prescription or Supplement:

- \_\_\_\_\_; Dose \_\_\_\_\_ mg \_\_\_\_\_ x a day \_\_\_\_\_ outcome
- \_\_\_\_\_; Dose \_\_\_\_\_ mg \_\_\_\_\_ x a day \_\_\_\_\_ outcome
- \_\_\_\_\_; Dose \_\_\_\_\_ mg \_\_\_\_\_ x a day \_\_\_\_\_ outcome
- \_\_\_\_\_; Dose \_\_\_\_\_ mg \_\_\_\_\_ x a day \_\_\_\_\_ outcome
- \_\_\_\_\_; Dose \_\_\_\_\_ mg \_\_\_\_\_ x a day \_\_\_\_\_ outcome
- \_\_\_\_\_; Dose \_\_\_\_\_ mg \_\_\_\_\_ x a day \_\_\_\_\_ outcome
- \_\_\_\_\_; Dose \_\_\_\_\_ mg \_\_\_\_\_ x a day \_\_\_\_\_ outcome
- \_\_\_\_\_; Dose \_\_\_\_\_ mg \_\_\_\_\_ x a day \_\_\_\_\_ outcome
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- \_\_\_\_\_; Dose \_\_\_\_\_ mg \_\_\_\_\_ x a day \_\_\_\_\_ outcome
- \_\_\_\_\_; Dose \_\_\_\_\_ mg \_\_\_\_\_ x a day \_\_\_\_\_ outcome
- \_\_\_\_\_; Dose \_\_\_\_\_ mg \_\_\_\_\_ x a day \_\_\_\_\_ outcome
- \_\_\_\_\_; Dose \_\_\_\_\_ mg \_\_\_\_\_ x a day \_\_\_\_\_ outcome



## SYMPTOM CHECKLIST

### CFIDS Cineraria (circle one)

1. Yes\_\_\_\_ No\_\_\_\_ Has your fatigue not been lifelong (i.e., you weren't born severely tired); and not the result of ongoing exertion; and not substantially alleviated by rest; and results in substantial reduction in previous levels of occupational, educational, social, or personal activities?
2. Yes\_\_\_\_ No \_\_\_\_ Do you have four or more of the following eight symptoms (please check the letter(s) of all that apply? All of which must have persisted or recurred during the six or more consecutive months of illness and must not have significantly predated the fatigue.  
\_\_\_\_ A. Impairment in short-term memory or concentration severe enough to cause substantial reduction in previous levels of personal activity  
\_\_\_\_ B. Sore throat  
\_\_\_\_ C. Tender neck or axillary (armpit) lymph nodes  
\_\_\_\_ D. Muscle pain  
\_\_\_\_ E. Multijoint pain without joint swelling or redness  
\_\_\_\_ F. Headaches of new type, pattern, or severity  
\_\_\_\_ G. Unrefreshing sleep  
\_\_\_\_ H. Post-exertional fatigue lasting more than 24 hours

### Fibromyalgia Criteria (circle one)

1. Yes\_\_\_\_ No\_\_\_\_ Have you had chronic widespread pain for more than three months in all four quadrants of the body (i.e., above and below the waist and on both sides of the body) and also axial pain (i.e., headache or pain around the spine or chest)? (These don't all have to be at the same time).
2. Please rate the following on a scale of 1 (near dead) to 10 (excellent) (circle the number that applies):
  - A. How is your energy?  
1    2    3    4    5    6    7    8    9    10  
1 = near dead and 10 = excellent
  - B. How is your sleep?  
1    2    3    4    5    6    7    8    9    10  
1 = no sleep and 10 = 8 hours of sleep a night without waking
  - C. How is your mental clarity?  
1    2    3    4    5    6    7    8    9    10  
1 = brain dead and 10 = good clarity
  - D. How bad is your achy-ness?  
1    2    3    4    5    6    7    8    9    10  
1 = very severe pain and 10 = pain free
  - E. How is your overall sense of well-being?  
1    2    3    4    5    6    7    8    9    10  
1 = near dead and 10 = excellent

### Physical Information

1. Give a representative blood pressure: \_\_\_\_\_
2. How much do you weigh? \_\_\_\_\_ lbs; \_\_\_\_\_ kg
3. Height: \_\_\_\_\_ inches; \_\_\_\_\_ cm



**Females only** – Have you had:

- 1) A hysterectomy \_\_\_\_\_ If yes, how long ago \_\_\_\_\_
- 2) Ovaries removed \_\_\_\_\_ (circle) One Both If yes, how long ago \_\_\_\_\_
- 3) A tubal ligation \_\_\_\_\_ If yes, how long ago \_\_\_\_\_

\_\_\_\_\_ Are your symptoms worse the week before your period? (**Females only**)

\_\_\_\_\_ Decreased libido

**Vasodepressor Syncope (NMH)**

\_\_\_\_\_ Disequilibrium

\_\_\_\_\_ Did you ever have a Tilt Table Test

If yes, was it \_\_\_\_\_ positive \_\_\_\_\_ normal

\_\_\_\_\_ Do you feel like you've been "hit by a truck" the day after exercise

**Prostatitis (males only)**

\_\_\_\_\_ Burning on urination

\_\_\_\_\_ Groin aching

\_\_\_\_\_ Discharge from your penis (not with ejaculation)

\_\_\_\_\_ Urine urgency with a small volume

**Sinusitis/Nasal congestion & Other Infections**

\_\_\_\_\_ Chronic nasal congestion or post nasal drip

\_\_\_\_\_ Chronic yellow or green nasal discharge

\_\_\_\_\_ Chronic bad taste in your mouth or bad breath

\_\_\_\_\_ Headaches under or over eyes

\_\_\_\_\_ Scratchy/watery eyes

\_\_\_\_\_ Do you have chronic or intermittent low-grade fevers (over 99° F/ \_\_\_\_\_ °C).

1, If yes, how high does the fever go \_\_\_\_\_

2. Did your illness begin with a fever \_\_\_\_\_

3. Do you have lung congestion \_\_\_\_\_

4. How often do you have the fever \_\_\_\_\_

\_\_\_\_\_ Has any antibiotic you've been on in the past even temporarily improved your Chronic Fatigue/fibromyalgia symptoms

If yes, which \_\_\_\_\_

How long did you take it \_\_\_\_\_

**Disordered Sleep**

\_\_\_\_\_ Trouble \_\_\_\_\_ falling \_\_\_\_\_ staying asleep? If yes, is it \_\_\_\_\_ mild, \_\_\_\_\_ moderate, or \_\_\_\_\_ severe.

\_\_\_\_\_ How many hours of uninterrupted sleep do you get a night \_\_\_\_\_

\_\_\_\_\_ Do you wake up during the night? If so, how often \_\_\_\_\_

\_\_\_\_\_ Do you wake at night to urinate

\_\_\_\_\_ Do your legs jump a lot or do you kick your spouse or kick your blankets off at night

\_\_\_\_\_ Do you snore? If yes:

\_\_\_\_\_ 1) Are you more than 20lbs overweight

\_\_\_\_\_ 2) Do you have periods that you stop breathing (ask your bed partner)

\_\_\_\_\_ 3) Do you have high blood pressure

### Yeast Overgrowth

- \_\_\_\_\_ Recurrent vaginal yeast infections (**females**). If so, how often \_\_\_\_\_
- \_\_\_\_\_ Toenail or fingernail fungal changes
- \_\_\_\_\_ Skin fungal infections (i.e., athlete's foot, jock itch, rash under bra)
- \_\_\_\_\_ Do you get in the mouth sores frequently (not on lips)
- \_\_\_\_\_ Do you get cold sores or Herpes attacks before or during symptom flares that seems to flare your symptoms
- \_\_\_\_\_ Been on birth control pills  
If yes, how did you feel on them? \_\_\_\_\_ better; \_\_\_\_\_ worse; \_\_\_\_\_ no change
- \_\_\_\_\_ Small amounts of alcohol aggravate symptoms

### Parasites

- \_\_\_\_\_ did your problems begin with a diarrhea attack
- \_\_\_\_\_ Do you sometimes have diarrhea? If so, is it severe \_\_\_\_\_
- \_\_\_\_\_ Do you sometimes have constipation
- \_\_\_\_\_ Do you have well water

### Vision/Dental

- \_\_\_\_\_ Double vision
- \_\_\_\_\_ Constantly changing eyeglass prescriptions
- \_\_\_\_\_ Blurred vision or halos around lights at night
- \_\_\_\_\_ Have you had temporary vision loss in one eye  
Which one \_\_\_\_\_  
How many times \_\_\_\_\_  
Is your sedimentation (sed) rate blood test over 30 \_\_\_\_\_
- \_\_\_\_\_ Dry eyes
- \_\_\_\_\_ Dry mouth
- \_\_\_\_\_ Any evidence of dental infections
- \_\_\_\_\_ Metallic taste in mouth
- \_\_\_\_\_ Light sensitivity or trouble focusing at night

### Other Problems and Questions

- \_\_\_\_\_ Do you drink non-diet sodas or other sweetened drinks? If so, how much? \_\_\_\_\_ ounces a day
- \_\_\_\_\_ Do you drink coffee?  
If so, how many 8oz. (American)/240cc (Metric) cups a day? Regular \_\_\_\_\_ Decaf \_\_\_\_\_
- \_\_\_\_\_ Do you drink alcohol? If so, how many drinks per day on average? \_\_\_\_\_
- \_\_\_\_\_ Do you smoke cigarettes? If yes, \_\_\_\_\_ packs a day
- \_\_\_\_\_ How much can you exercise? \_\_\_\_\_
- \_\_\_\_\_ Besides your illness, what other stresses are going on in your life? \_\_\_\_\_  
\_\_\_\_\_
- \_\_\_\_\_ Do you have frequent and persistent infections? If yes, what kind? \_\_\_\_\_
- \_\_\_\_\_ A rash? What does it look like? \_\_\_\_\_  
How long have you had it? \_\_\_\_\_  
Does it \_\_\_\_\_ itch, \_\_\_\_\_ burn or \_\_\_\_\_ sting?

**Other Problems and Questions Continued. . .**

\_\_\_\_\_ Chest pain

How long have you had it \_\_\_\_\_

Has it been \_\_\_\_\_ getting better, \_\_\_\_\_ getting worse, \_\_\_\_\_ staying the same

With exercise (e.g., walking steps) the pain

\_\_\_\_\_ increases, \_\_\_\_\_ decreases, or \_\_\_\_\_ stays the same

With exercise do you have:

\_\_\_\_\_ shortness of breath

\_\_\_\_\_ chest tightness

\_\_\_\_\_ pain radiating to your left arm

\_\_\_\_\_ sweating

Can you worsen the same chest pain by pushing on your chest muscles \_\_\_\_\_

Are the chest pains \_\_\_\_\_ sharp, \_\_\_\_\_ dull, \_\_\_\_\_ worse with position change or deep breath

Are your chest pains mostly when you're relaxing (not exercising) \_\_\_\_\_

During the chest pains, do you have (check all that apply):

\_\_\_\_\_ Feeling of being unable to take a deep enough breath

\_\_\_\_\_ Numbness and/or tingling in hands and toes

\_\_\_\_\_ Numbness and/or tingling around the mouth

\_\_\_\_\_ Spacey feelings

\_\_\_\_\_ Feeling of panic or impending death

Do you smoke cigarettes \_\_\_\_\_ How many packs a day \_\_\_\_\_ For how many years \_\_\_\_\_

Did your father, mother, sister(s) or brother(s) have angina? \_\_\_\_\_

If yes, did they have it before age 65 \_\_\_\_\_

Do you have high cholesterol \_\_\_\_\_ Approximately how high \_\_\_\_\_

Do you have Diabetes \_\_\_\_\_

Do you have high blood pressure \_\_\_\_\_

Recurrent palpitations \_\_\_\_\_

Palpitations last over 20 seconds \_\_\_\_\_

Pulse \_\_\_\_\_ regular or \_\_\_\_\_ irregular

Pulse over 120/minutes \_\_\_\_\_

Get dizzy with palpitations \_\_\_\_\_

Take Thyroid hormones \_\_\_\_\_

\_\_\_\_\_ Shortness of breath

Comes and go suddenly (not with exercise) \_\_\_\_\_

Wake up short of breath at night \_\_\_\_\_ (if yes, answer the following)

Do you have ankle swelling \_\_\_\_\_

Do you get short of breath if you lay flat \_\_\_\_\_

If yes, how many pillows do you sleep on \_\_\_\_\_

Worse with exertion \_\_\_\_\_

How many flights of steps \_\_\_\_\_

\_\_\_\_\_ Transient weakness/paralysis in one arm and/or leg

Is it always on the same

\_\_\_\_\_ Ankle swelling

Any unusual weight loss? If yes,  lb/kg, over  years,  years ago. Describe what happened: \_\_\_\_\_

Numbness or tingling around your lips or mouth

Blood in your stool  
 Is it only bright red blood on your toilet tissue or on stool (not mixed in) \_\_\_\_\_  
 If yes, do you have Hemorrhoids   
 If no, answer the following:  
 Is the blood mixed in (not only on) your stool   
 Do you have bloody mucus with stools  How often \_\_\_\_\_  
 Do you have painful bowel movements   
 Has your doctor done:  

<u>When</u>	<u>Result/Diagnoses</u>
<input type="checkbox"/> a colonoscopy	<input type="checkbox"/>
<input type="checkbox"/> a Sigmoidoscopy	<input type="checkbox"/>
<input type="checkbox"/> a Barium Enema	<input type="checkbox"/>
<input type="checkbox"/> none of these	<input type="checkbox"/>

 Have your bowel movements gotten thinner (e.g., pencil like) \_\_\_\_\_  
 Have you had a lot of:  
 constipation  
 diarrhea  
 both  
 neither

Cough up blood? How long has it been going on \_\_\_\_\_  
 Have you had a chest x-ray since this began \_\_\_\_\_  
 If yes, when? \_\_\_\_\_ what did it show \_\_\_\_\_

Frequently cough up yellow mucus  
 Have you had a chest x-ray since this began \_\_\_\_\_  
 If yes, when? \_\_\_\_\_ what did it show \_\_\_\_\_

Chronic cough? If yes, for how long \_\_\_\_\_  
 Have you had a chest x-ray since this began \_\_\_\_\_  
 If yes, when? \_\_\_\_\_ what did it show \_\_\_\_\_

Chronic burning when you urinate and urinary urgency even with small volumes  
 Have you had urine cultures checked \_\_\_\_\_  
 If no, check urine culture during symptoms.  
 If yes, do they usually show infection \_\_\_\_\_  
 If no:  
 Male – do you have discharge from your penis when you wake in the morning \_\_\_\_\_  
 Female – Is this a severe problem? \_\_\_\_\_ If no – take no action

Chronic anal/rectal pain

Any breast lump that you have had for more than 6 weeks  
 If yes, which breast \_\_\_\_\_  
 Are you breastfeeding? If yes – skip to next question  
 Is it,  milky,  pus,  bloody,  clear  
 Is it in,  right breast,  left breast,  both breasts  
 How long have you had it? \_\_\_\_\_

- \_\_\_\_\_ Do you have any other lumps or bumps that are new or growing  
Please describe \_\_\_\_\_
- \_\_\_\_\_ Have you had problems with infertility?  
If yes, do you still want to have a (or another) child \_\_\_\_\_
- \_\_\_\_\_ If female, when was your last period \_\_\_\_\_ Over 3 months ago; \_\_\_\_\_ days ago
- \_\_\_\_\_ Does food often stick in your food pipe  
How long has this been going on \_\_\_\_\_
- \_\_\_\_\_ Does your tongue burn
- A) Has your tongue become smooth with cracks/fissures \_\_\_\_\_
- B) Do you have a white coating throughout your mouth \_\_\_\_\_
- C) Do you have a white coating on your tongue \_\_\_\_\_
- D) Do small taste buds sometimes become inflamed and painful \_\_\_\_\_
- \_\_\_\_\_ Any history of psychiatric illness? Please describe: \_\_\_\_\_
- \_\_\_\_\_ Any other symptoms(s) or problem(s) (please don't be bashful, list them all \_\_\_\_\_
- 
- \_\_\_\_\_ Are you married? If so, how long \_\_\_\_\_ Is he or she supportive \_\_\_\_\_
- \_\_\_\_\_ Did you have/need to change jobs or decrease how much you work because of your illness  
If so, please describe: \_\_\_\_\_
- \_\_\_\_\_ Besides those already discussed:
- A) What things or treatments have you found helpful in the past \_\_\_\_\_
- B) What things or treatments have you tried without benefit? \_\_\_\_\_
- C) What things or treatments have made you feel worse in the past \_\_\_\_\_
- \_\_\_\_\_ What medical problems do or did your parents or siblings have? If they died, note cause and approx. age at death.
- Mother: \_\_\_\_\_
- Father: \_\_\_\_\_
- Brothers: \_\_\_\_\_
- Sisters: \_\_\_\_\_
- \_\_\_\_\_ Do you feel depressed (as opposed to frustrated over not being able to function)
- \_\_\_\_\_ Do you have suicidal thoughts
- \_\_\_\_\_ Have you traveled out of the country in the 6 weeks before your illness began? If yes:
- \_\_\_\_\_ Did you get diarrhea while traveling?
- \_\_\_\_\_ Did you eat fish in the Caribbean area in the 6 weeks before your illness began? If yes:
- \_\_\_\_\_ Did you eat Barracuda?
- \_\_\_\_\_ Did you have unusual feelings in your teeth or metallic taste in your mouth?
- \_\_\_\_\_ Did you have a lot of numbness and tingling in your fingers and/or toes?
- \_\_\_\_\_ Is your energy and mental clarity improved when you take Codeine (e.g., Darvon, Percocet, Vicoden, etc.)?
- \_\_\_\_\_ Beck Depression Inventory (total for A through V below)
- \_\_\_\_\_ Please write about your experience with the illness. How it began, how it affects your life, what it feels like, significant factors and anything else your doctor may find helpful.
- 
-

## BECK INVENTORY

On this questionnaire are groups of statements. Please read each group of statements carefully. Then pick out the one statement in each group which best describes the way you have been feeling the **past week, including today!** Check the number beside the statement you picked. If several statements in each group seem to apply equally as well, circle the one that seems closest. **Be sure to read all the statements in each group before making your choice.**

- A. \_\_\_0 I do not feel sad.  
\_\_\_1 I feel sad.  
\_\_\_2 I am sad all the time and can't snap out of it.  
\_\_\_3 I am so sad or unhappy that I can't stand it.
- B. \_\_\_0 I am not particularly discouraged about the future.  
\_\_\_1 I feel discouraged about the future.  
\_\_\_2 I feel I have nothing to look forward to.  
\_\_\_3 I feel that the future is hopeless and that things cannot improve.
- C. \_\_\_0 I do not feel like a failure.  
\_\_\_1 I feel I have failed more than the average person.  
\_\_\_2 As I look back on my life, all I can see is a lot of failures.  
\_\_\_3 I feel I am a complete failure as a person.
- D. \_\_\_0 I get as much satisfaction out of things as I used to.  
\_\_\_1 I don't enjoy things the way I used to.  
\_\_\_2 I don't get real satisfaction out of anything anymore.  
\_\_\_3 I am dissatisfied or bored with everything.
- E. \_\_\_0 I don't feel particularly guilty.  
\_\_\_1 I feel guilty a good part of the time.  
\_\_\_2 I feel quite guilty most of the time.  
\_\_\_3 I feel guilty all of the time.
- F. \_\_\_0 I don't feel I am being punished.  
\_\_\_1 I feel I may be punished.  
\_\_\_2 I expect to be punished.  
\_\_\_3 I feel I am being punished.
- G. \_\_\_0 I don't feel disappointed in myself.  
\_\_\_1 I am disappointed in myself.  
\_\_\_2 I am disgusted with myself.  
\_\_\_3 I hate myself.
- H. \_\_\_0 I don't feel I am any worse than anybody else.  
\_\_\_1 I am critical of myself for my weaknesses or mistakes.  
\_\_\_2 I blame myself all the time for my faults.  
\_\_\_3 I blame myself for everything bad that happens.
- I. \_\_\_0 I don't have any thoughts of killing myself.

- \_\_\_1 I have thoughts of killing myself, but would not carry them out.  
 \_\_\_2 I would like to kill myself.  
 \_\_\_3 I would kill myself if I had the chance.
- J. \_\_\_0 I don't cry any more than usual.  
 \_\_\_1 I cry more now than I used to.  
 \_\_\_2 I cry all the time now.  
 \_\_\_3 I used to be able to cry, but now I can't cry even though I want to.
- K. \_\_\_0 I am no more irritated now than I ever am.  
 \_\_\_1 I get annoyed or irritated more easily than I used to.  
 \_\_\_2 I feel irritated all the time now.  
 \_\_\_3 I don't get irritated at all by the things that used to irritate me.
- L. \_\_\_0 I have not lost interest in other people.  
 \_\_\_1 I am less interested in other people than I used to be.  
 \_\_\_2 I have lost most of my interest in other people.  
 \_\_\_3 I have lost all of my interest in other people.
- M. \_\_\_0 I make decisions about as well as I ever could.  
 \_\_\_1 I put off making decisions more than I used to.  
 \_\_\_2 I have greater difficulty in making decisions than before.  
 \_\_\_3 I can't make decisions at all anymore.
- N. \_\_\_0 I don't feel I look any worse than I used to.  
 \_\_\_1 I am worried that I am looking old or unattractive.  
 \_\_\_2 I feel that there are permanent changes in my appearance that make me look unattractive.  
 \_\_\_3 I believe that I look ugly.
- O. \_\_\_0 I can work about as well as before.  
 \_\_\_1 It takes an extra effort to get started at doing something.  
 \_\_\_2 I have to push myself very hard to do anything.  
 \_\_\_3 I can't do any work at all.
- P. \_\_\_0 I can sleep as well as usual.  
 \_\_\_1 I don't sleep as well as I used to.  
 \_\_\_2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.  
 \_\_\_3 I wake up several hours earlier than I used to and I cannot get back to sleep.
- Q. \_\_\_0 I don't get more tired than usual.  
 \_\_\_1 I get tired more easily than I used to.  
 \_\_\_2 I get tired from doing almost anything.  
 \_\_\_3 I am too tired to do anything.
- R. \_\_\_0 My appetite is no worse than usual.  
 \_\_\_1 My appetite is not as good as it used to be.

- \_\_\_2 My appetite is much worse now.  
\_\_\_3 I have no appetite at all anymore.
- S. \_\_\_0 I haven't lost much weight, if any, lately.  
\_\_\_1 I have lost more than 5 pounds.  
\_\_\_2 I have lost more than 10 pounds.  
\_\_\_3 I have lost more than 15 pounds.
- T. \_\_\_0 I am purposely trying to lose weight.  
\_\_\_1 I am not purposely trying to lose weight.
- U. \_\_\_0 I am not more worried about my health than usual.  
\_\_\_1 I am worried about physical such as aches and pains; or upset stomach; or constipation.  
\_\_\_2 I am very worried about physical problems and it's hard to think of much else.  
\_\_\_3 I am so worried about my physical problems and it's hard to think of much else.
- V. \_\_\_0 I have not noticed any recent change in my interest in sex.  
\_\_\_1 I am less interested in sex than I used to be.  
\_\_\_2 I am much less interested in sex now.  
\_\_\_3 I have lost interest in sex completely.

## YEAST QUESTIONNAIRE

The total score for this section gives us the probability of yeast overgrowth being a significant factor in your case.

### SECTION A: YOUR MEDICAL HISTORY

		Point
_____	Have you been treated for acne with tetracycline, erythromycin, or any other antibiotic for one month or longer?	50
_____	Have you taken antibiotics for any type of infection for more than two consecutive months, or in shorter courses four or more times in a twelve-month period?	50
_____	Have you ever taken an antibiotic – even for a single course?	6
_____	Have you ever had prostatitis, vaginitis, or another infection or problem with your reproductive organs for more than one month?	25
_____	Have you ever been pregnant: Two or more times?	5
_____	Once?	3
_____	Have you taken birth control pills for: More than two years?	15
_____	Six months to two years?	
_____	Have you taken corticosteroids such as Prednisone, Cortef, or Medrol by mouth or inhaler for: More than two weeks?	15
_____	Two weeks or less?	6
_____	When you are exposed to perfumes, insecticides, or other odors or chemicals, do you develop wheezing, burning eyes, taste metal in your mouth or any other distress? Yes, and the symptoms keep me from continuing my activities.	20
_____	Yes, but the symptoms are mild and do not change my activities.	5
_____	Are your symptoms worse on damp or humid days or in moldy places?	20
_____	Have you ever had a fungal infection, such as jock itch, athlete's foot, or a nail or skin infection, that was difficult to treat and: Lasted for more than two months?	20
_____	Lasted less than two months?	10
_____	Do you crave? Sugar?	10
_____	Breads?	10
_____	Alcoholic beverages?	10
_____	Does tobacco smoke cause you discomfort such as wheezing, burning eyes, or another problem?	10
	Total	_____

## SECTION B: MAJOR SYMPTOMS

For each symptom that is present, enter the appropriate number in the point score column:

- |   |                 |
|---|-----------------|
| If a symptom is occasional or mild                | Score 3 points. |
| If a symptom is frequent and/or moderately severe | Score 6 points. |
| If a symptom is severe and/or disabling           | Score 9 points. |

Score	Point
1. Fatigue or lethargy.	_____
2. Feeling of being "drained."	_____
3. Poor memory.	_____
4. Feeling "spacey" or "unreal."	_____
5. Inability to make decisions.	_____
6. Numbness, burning, or tingling.	_____
7. Insomnia.	_____
8. Muscle aches.	_____
9. Muscle weakness or paralysis.	_____
10. Pain and/or swelling in joints.	_____
11. Abdominal pain.	_____
12. Constipation.	_____
13. Diarrhea.	_____
14. Bloating, belching or intestinal gas.	_____
15. Troublesome vaginal burning, itching, or discharge.	_____
16. Prostatitis	_____
17. Impotence	_____
18. Loss of sexual desire or feeling	_____
19. Endometriosis or infertility	_____
20. Cramps and/or other menstrual irregularities	_____
21. Premenstrual tension	_____
22. Attacks of anxiety or crying	_____
23. Cold hands or feet and/or Chilliness	_____
24. Shaking or irritable when hungry	_____

### Section C: Other Symptoms

For each symptom that is present, enter the appropriate figure in the point score column.

If a symptom is occasional or mild

Score 1 point

If a symptom is frequent and/or moderately severe

Score 2 points

If a symptom is severe and/or persistent

Score 3 points

#### Symptom

#### Point Score

- |  |       |
|--|-------|
| 1. Drowsiness  | _____ |
| 2. Irritability or jitteriness                       | _____ |
| 3. Lack of coordination                              | _____ |
| 4. Inability to concentrate                          | _____ |
| 5. Frequent moos swings                              | _____ |
| 6. Headache  | _____ |
| 7. Dizziness, loss of balance                        | _____ |
| 8. Pressure above ears, feeling of head swelling     | _____ |
| 9. Tendency to bruise easily                         | _____ |
| 10. Chronic rashes or itching                        | _____ |
| 11. Psoriasis or recurrent hives                     | _____ |
| 12. Indigestion or heartburn                         | _____ |
| 13. Food sensitivity or intolerance                  | _____ |
| 14. Mucous in stools                                 | _____ |
| 15. Rectal itching                                   | _____ |
| 16. Dry mouth or throat                              | _____ |
| 17. Rash or blisters in mouth                        | _____ |
| 18. Bad breath                                       | _____ |
| 19. Foot, hair, or body odor not relieved by washing | _____ |
| 20. Nasal congestion or postnasal drip               | _____ |
| 21. Nasal itching                                    | _____ |
| 22. Sore Throat                                      | _____ |
| 23. Laryngitis, loss of voice                        | _____ |
| 24. Cough or recurrent bronchitis                    | _____ |
| 25. Pain or tightness in chest                       | _____ |
| 26. Wheezing or shortness of breath                  | _____ |
| 27. Urinary frequency, urgency, or incontinence      | _____ |
| 28. Burning on urination                             | _____ |
| 29. Spots in front of eyes or erratic vision         | _____ |
| 30. Burning or tearing of eyes                       | _____ |
| 31. Recurrent infections or fluids in ears           | _____ |
| 32. Ear pain or deafness                             | _____ |

Total – page 21 \_\_\_\_\_

Total – page 19 \_\_\_\_\_

Total – page 18 \_\_\_\_\_

## Lyme Disease and Associated Infections

**Do you now or have you ever had the following:**

Have you ever been diagnosed with the any of the following:

- Multiple Sclerosis
- Chronic Fatigue
- Bipolar Disorder
- Obsessive Compulsive Disorder
- Attention Deficit Disorder
- Autism like syndrome
- Fibromyalgia
- Arthritis
- Bell's Palsy

## Please check any of the Following that Apply

- History of frequent tick bites (regardless of how long ago) If so, how many? \_\_\_\_\_
- Rash after tick bite
- Rash that looked like a "bull's eye"
- Have you been treated for Lyme disease
- Numbness or tingling in your fingers or feet
- History or a positive Lyme test
- Have you ever lived in a Lyme endemic area
- Did your symptoms begin soon or immediately after:
  - pregnancy
  - an accident? If so, how soon \_\_\_\_\_
  - after a vacation
  - moving into a new home
- Abdominal pains? Describe \_\_\_\_\_
- Have you ever had a symptom flare while taking a course of antibiotics
- Has any antibiotic you've been on in the past even temporarily improved your Chronic Fatigue/fibromyalgia symptoms
  - If yes, which \_\_\_\_\_
  - How long did you take it \_\_\_\_\_
- Do you have symptoms that flare every four weeks or are cyclic in nature
- Fatigue, tiredness, poor stamina
- Unexplained thinning hair
- Exaggerated symptoms or worse hangover from alcohol
- Stabbing sensations, shooting pains, skin hypersensitivity
- Neck creaks & cracks / Neck stiffness, pain
- Unexplained weight loss or gain
- Muscle pain or cramps
- Dental pain
- Joint pain and/or joint swelling
- Chest wall pain or sore ribs
- Swollen glands
- Chronic nasal congestion or post nasal drip

- Burning or stabbing sensations / Shooting pains
- Disturbed sleep: too much, too little, fractionated, early awakening
- Confusion and/or difficulty thinking, writing, forgetfulness
- Difficulty with concentration, reading, speaking, absorbing new information. . .
- Speech errors or speak the wrong words
- Disorientation and getting lost
- Increased motion sickness, vertigo or spinning
- Poor short-term memory
- Inability to recognize and/or name common items, such as tooth brush, can opener. . . .
- Panic attacks / anxiety
- Irritability
- Psychosis
- Depression
- Rapid mood swings
- Numbness
- Facial paralysis – Bell's Palsy
- Tingling
- Light or sound sensitivity
- Tremor and/or seizures
- Ringing in ears
- Hearing loss
- Light or sound sensitivity
- Skin hypersensitivity
- Twitching of the face or other muscles
- Sexual dysfunction or loss of libido
- Pelvic pain
- Testicular pain
- Unexplained breast pain
- Unexplained menstrual irregularity'
- Unexplained milk production
- Do you have chronic vulvar or vaginal pain? **(For females only)**
  - If yes:  Only with intercourse
  - Even not with intercourse
- Heart palpitations
- Pulse skips
- Pain in your Feet (check all that apply):
  - Pain by heel, worse with walking
  - Pain over most of the sole(s) of your feet on walking
  - Shooting/burning pain between 2 of your toes that is worse when you squeeze that area
  - Horrible pain in one foot (whole foot – not only one joint) that's been occurring for more than 6 weeks and makes you want to be sure no one touches it
    - Does the foot often feel cooler or warmer to the touch than the other and looks either pale or red
    - Did you have an injury or surgery to this foot or the hip on the same side before the pain began

- \_\_\_\_\_ Pain in your Hands (check all that apply)
- \_\_\_\_\_ Horrible pain in one hand (whole hand – not only one joint) that's been occurring for more than 6 weeks and makes you want to be sure no one touches it
- \_\_\_\_\_ Does the hand often feel cooler or warmer to the touch than the other and looks either pale or red
- \_\_\_\_\_ Did you have an injury or surgery to this hand or the shoulder on the same side before the pain began
- \_\_\_\_\_ Redness and swelling in one or more joints in hands or feet
- \_\_\_\_\_ In one hand \_\_\_\_\_ In one foot
- \_\_\_\_\_ In both hands \_\_\_\_\_ In both feet
- If yes, do you have a history of:
- \_\_\_\_\_ Gout
- \_\_\_\_\_ Rheumatoid Arthritis
- \_\_\_\_\_ Other Arthritis, please specify \_\_\_\_\_

## Co Infections - Please Check all that Apply

### Babesiosis

- |                                 |                                  |
|---------------------------------|----------------------------------|
| _____ Fever                     | _____ Headaches                  |
| _____ Shaking chills            | _____ Anemia                     |
| _____ Cough                     | _____ High Fever                 |
| _____ Imbalance                 | _____ Immune deficiency          |
| _____ Dark urine/blood in urine | _____ Jaundice                   |
| _____ Anemia                    | _____ Sore Throat                |
| _____ Malaise                   | _____ Raised reddish/purple rash |
| _____ Sweats                    |                                  |
| _____ Increased sense Déjà vu   |                                  |
| _____ Night sweats              |                                  |
| _____ Headaches                 |                                  |
| _____ Air hunger                |                                  |
| _____ Weakness/Fatigue          |                                  |
| _____ Abdominal Pain            |                                  |
| _____ Nausea                    |                                  |
| _____ Diarrhea                  |                                  |
| _____ Neck/back stiffness       |                                  |

### Ehrlichia

- \_\_\_\_\_ Headaches
- \_\_\_\_\_ Myalgias
- \_\_\_\_\_ Ongoing fatigue
- \_\_\_\_\_ Nose bleeds
- \_\_\_\_\_ Decrease white blood cell count
- \_\_\_\_\_ Low platelets in blood
- \_\_\_\_\_ Bleeding gums
- \_\_\_\_\_ Bruising
- \_\_\_\_\_ Purpura

### Bartonella

- \_\_\_\_\_ Depression
- \_\_\_\_\_ Stomach pain
- \_\_\_\_\_ Pain on soles of feet
- \_\_\_\_\_ Muscle Twitching
- \_\_\_\_\_ Dementia
- \_\_\_\_\_ Abdominal Pain
- \_\_\_\_\_ Myalgias
- \_\_\_\_\_ Combative behavior
- \_\_\_\_\_ Flu-like malaise
- \_\_\_\_\_ Red.purple rash Under skin on Forearms