

Annapolis Integrative Medicine Chronic Fatigue/Fibromyalgia Questionnaire

**Alan S Weiss MD
Annapolis Integrative Medicine
1819 Bay Ridge Ave
Suite 200
Annapolis, MD 21403**

AnnapolisIntegrativeMedicine.com

**Phone: 410-266-3613
Fax: 410-266-6104**

CHRONIC FATIGUE/FIBROMYALGIA INFORMATION QUESTIONNAIRE

Reason for Appointment: _____

How did you find out about Annapolis Integrative Medicine? _____

Name: _____

Date of Birth: _____

Date: _____

E-mail Address: _____

Address: _____

Home Phone: () _____ **Work Phone:** () _____

Cell Phone: () _____ **Fax:** () _____

Where were you born? _____

Occupation: _____

Are you married, single, separated, divorced, widowed? (Circle one)

If married, when were you married? _____

How many children do you have?

Annapolis Integrative Medicine Chronic Fatigue/Fibromyalgia Questionnaire

NAME

AGE

FAMILY HISTORY

What medical problems do or did your parents or siblings have? (If they died note cause and approximate age at death)

Mother: _____

Father: _____

Brothers: _____

Sisters: _____

Other family histories of importance-if present say who:

1. Colon Cancer?
2. Coronary Artery Disease at age less than 60?
3. Prostate/Breast/Ovarian Cancer?
4. Thyroid Disease?
5. Auto-Immune or Connective Tissue Disorder (i.e. Lupus, Rheumatoid Arthritis)?

Are you allergic to any medications? Circle One: Yes No

Please List:

Personal Risk Factors

Do you or have you smoked or chewed tobacco?

(If so: How long _____ How many packs per days _____)

Do you drink alcohol? If so, how much? _____

Do you drink coffee/tea/ or other caffeinated drinks? If so, how much daily? _____

Diet

Annapolis Integrative Medicine Chronic Fatigue/Fibromyalgia Questionnaire

Describe your diet:

1. Typical Breakfast: _____
2. Typical Lunch: _____
3. Typical Dinner: _____
4. Snacks: Type and Timing: _____

Do you have any food allergies? _____

If yes, how do you know (from a test, from symptoms, etc) _____

Do you use artificial sweeteners? If so which one(s) and how much (include diet soda):

How much sugar do you use? In what form (sugar in coffee, soda, etc):

Do you eat "junk food" or "fast food"? If so, what and how often?

How much water do you drink?

Exercise

Are you able to exercise? If so, how much and what type?

If you used to exercise more before your illness, how much and what type of exercise?

Did you have a healthy childhood? If not, how often were you ill and with what?

WHEN WERE YOU LAST “WELL”?

HISTORY OF CURRENT ILLNESS

Please describe briefly what your main problem(s) are and when they began:

How abruptly did your symptoms start- All at once (or) over a period of time?)

What was happening in your life in terms of stress at the time? Consider work, family, romance, finances, and illness of you or others, or any other type of situational stress:

How much has fatigue decreased your function? ____%

What symptoms presented at onset?

At the onset of your illness:

- How many hours/week were you working (including commute)? _____
- Hours spent weekly on your children's care at onset? _____

Annapolis Integrative Medicine Chronic Fatigue/Fibromyalgia Questionnaire

NOW,

- How many hours/week do you work? _____
- Children's care? _____ hrs/wk

Do you enjoy your job?

How many doctors have you seen for your symptoms?

Have you been to any specialists at University Centers? _____

What part of the day do you typically feel:

- a. Best? _____
- b. Worst? _____

Routine Health Maintenance:

Colonoscopy:	When?	Result
Women:		
a. Mammogram:	When?	Result
b. Pap Smear:	When?	Result
c. Bone Density Test:	When?	Result
Men:		
a. PSA (prostate-specific antigen)	When?	Result

Check any of these that you have or have had and **write date of onset next to condition:**

1. _____ **Stroke(s)**

Annapolis Integrative Medicine Chronic Fatigue/Fibromyalgia Questionnaire

- 2. ____ **Multiple Sclerosis**
- 3. ____ **Neuropathies - If so, what type?**
- 4. ____ **Glaucoma**
- 5. ____ **Cataracts**
- 6. ____ **Lupus**
- 7. ____ **Rheumatoid Arthritis**
- 8. ____ **Osteo-Arthritis ("wear & tear" arthritis)**
- 9. ____ **Scleroderma**
- 10. ____ **Other Rheumatic Diseases (List them):**

11. ____ Phlebitis and/or Pulmonary Embolus

If yes, did it go to your lungs? ____ (i.e., Pulmonary Embolus)

12. ____ Angina or heart attack (Myocardial Infarction)

- 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? _____

13. ____ Diagnosis of Arrhythmia (abnormal heart rhythm)

14. ____ Mitral Valve Prolapse

15. ____ Heart valve disease? Which? _____

16. ____ Are you on blood thinners?

If so, check which one and fill in dose

- | | |
|-------------------------|--------------------|
| ____ Coumadin/Warfarin- | Dose ____ mg a day |
| ____ Heparin- | Dose ____ mg a day |
| ____ Aspirin- | Dose ____ mg a day |
| ____ Other: | Dose ____ mg a day |

17. ____ Have you been diagnosed with cancer?

What Type?

If yes –Is it Metastatic or Nonmetastatic _____,
If Metastatic, to where _____

Did you have (check all that apply):

Annapolis Integrative Medicine Chronic Fatigue/Fibromyalgia Questionnaire

(Think of new house, carpeting, paint, floods causing mold in the house as well as possible work exposures)

34. ____ Systemic Lupus or other Connective Tissue Disease

35. ____ Do you consider yourself an alcoholic?

36. ____ Kidney stones or other Kidney Disease

37. ____ Active Lumbar or Cervical Disc Disease (e.g., sciatica)

38. ____ Diabetes

- a. ____ Juvenile onset
- b. ____ Adult onset

39. ____ Pancreatitis

- a. If yes, from:
 - i. ____ Gallstones
 - ii. ____ Alcohol
 - iii. ____ Other cause
 - iv. ____ Unknown cause

40. Have you had any operations? Please list them:

- a. Year (approx) _____ Type of surgery _____
- b. Year (approx) _____ Type of surgery _____
- c. Year (approx) _____ Type of surgery _____

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

- a. Year (approx) _____
Reason: _____
- b. Year (approx) _____
Reason: _____

42. What other diagnoses do you have not covered above?

43. Does your insurance pay for medications? ____ yes; ____ no

Annapolis Integrative Medicine Chronic Fatigue/Fibromyalgia Questionnaire

If yes: _____% or \$_____ co pay; \$_____ limit per year.

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

<u>Treatment</u>	Check if you are currently taking	Check if you took in the past and stopped	If you discontinued the treatment give the single main reason	Dose you are <u>currently</u> 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	<input type="checkbox"/> Helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects	

Annapolis Integrative Medicine Chronic Fatigue/Fibromyalgia Questionnaire

<input type="checkbox"/> Injection <input type="checkbox"/> Other	<input type="checkbox"/> Doesn't Help <input type="checkbox"/> Don't Know if it helps		<input type="checkbox"/> Didn't Work <input type="checkbox"/> Too expensive	<input type="checkbox"/> mg; <input type="checkbox"/> x a day
Rx - Natural Estrogen 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	<input type="checkbox"/> mg; <input type="checkbox"/> x a day <input type="checkbox"/> every day <input type="checkbox"/> days per month
Rx - Other 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	<input type="checkbox"/> mg; <input type="checkbox"/> 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	<input type="checkbox"/> mg; <input type="checkbox"/> 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	<input type="checkbox"/> mg; <input type="checkbox"/> x a day <input type="checkbox"/> every day <input type="checkbox"/> days per month
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	<input type="checkbox"/> mg; <input type="checkbox"/> x a day <input type="checkbox"/> every day <input type="checkbox"/> days per month
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	<input type="checkbox"/> mg; <input type="checkbox"/> 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	<input type="checkbox"/> mg; <input type="checkbox"/> x a day
Rx – Flagyl (Metranidazole)	<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	<input type="checkbox"/> mg; <input type="checkbox"/> x a day
Rx – Yodoxin (Iodoquinol)	<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	<input type="checkbox"/> mg; <input type="checkbox"/> x a day
Rx – Doxycycline (Tetracycline)	<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	<input type="checkbox"/> mg; <input type="checkbox"/> x a day
Rx - Cipro (Ciprofloxacin)	<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	<input type="checkbox"/> mg; <input type="checkbox"/> x a day
Rx – Zoloft (Sertraline)	<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	<input type="checkbox"/> mg; <input type="checkbox"/> x a day
Rx – Paxil (Paroxetine)	<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	<input type="checkbox"/> mg; <input type="checkbox"/> x a day
Rx – Prozac (Fluoxetine)	<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	<input type="checkbox"/> mg; <input type="checkbox"/> x a day
Rx – Effexor (Venlafaxine)	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't Help	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work	<input type="checkbox"/> mg; <input type="checkbox"/> x a day

Annapolis Integrative Medicine Chronic Fatigue/Fibromyalgia Questionnaire

	___ Don't Know if it helps		___ Too expensive	
Rx – Serzone (Nefazodone)	___ Helps ___ Doesn't Help ___ Don't Know if it helps	___ Yes	___ Side Effects ___ Didn't Work ___ Too expensive	___ mg; ___ x a day
Rx – Wellbutrin (Bupropion)	___ Helps ___ Doesn't Help ___ Don't Know if it helps	___ Yes	___ Side Effects ___ Didn't Work ___ Too expensive	___ mg; ___ x a day
Rx - Baclofen	___ Helps ___ Doesn't Help ___ Don't Know if it helps	___ Yes	___ Side Effects ___ Didn't Work ___ Too expensive	___ mg; ___ x a day
Rx – Neurontin (Gabapentin)	___ Helps ___ Doesn't Help ___ Don't Know if it helps	___ Yes	___ Side Effects ___ Didn't Work ___ Too expensive	___ mg; ___ x a day
Calcium	___ Helps ___ Doesn't Help ___ Don't Know if it helps	___ Yes	___ Side Effects ___ Didn't Work ___ Too expensive	___ mg; ___ x a day
Chromagen (iron)	___ Helps ___ Doesn't Help ___ Don't Know if it helps	___ Yes	___ Side Effects ___ Didn't Work ___ Too expensive	___ mg; ___ x a day
DHEA	___ Helps ___ Doesn't Help ___ Don't Know if it helps	___ Yes	___ Side Effects ___ Didn't Work ___ Too expensive	___ mg; ___ x a day
Vitamin B12 ___ injections ___ sublingual	___ Helps ___ Doesn't Help ___ Don't Know if it helps	___ Yes	___ Side Effects ___ Didn't Work ___ Too expensive	___ mcg; ___ x a day
Acetyl-L-Carnitine	___ Helps ___ Doesn't Help ___ Don't Know if it helps	___ Yes	___ Side Effects ___ Didn't Work ___ Too expensive	___ mg; ___ x a day
Co Enzyme Q10	___ Helps ___ Doesn't Help ___ Don't Know if it helps	___ Yes	___ Side Effects ___ Didn't Work ___ Too expensive	___ mg; ___ x a day
L-Lysine	___ Helps ___ Doesn't Help ___ Don't Know if it helps	___ Yes	___ Side Effects ___ Didn't Work ___ Too expensive	___ mg; ___ x a day
Magnesium Potassium Aspartate	___ Helps ___ Doesn't Help ___ Don't Know if it helps	___ Yes	___ Side Effects ___ Didn't Work ___ Too expensive	___ mg; ___ x a day
NADH	___ Helps ___ Doesn't Help ___ Don't Know if it helps	___ Yes	___ Side Effects ___ Didn't Work ___ Too expensive	___ mg; ___ x a day

45. What other treatment(s) are you on?

Prescription:

1. _____; Dose ____mg _____ x a day
2. _____; Dose ____mg _____ x a day
3. _____; Dose ____mg _____ x a day
4. _____; Dose ____mg _____ x a day
5. _____; Dose ____mg _____ x a day
6. _____; Dose ____mg _____ x a day
7. _____; Dose ____mg _____ x a day
8. _____; Dose ____mg _____ x a day
9. _____; Dose ____mg _____ x a day
10. _____; Dose ____mg _____ x a day

Non-Prescription:

1. _____; Dose ____mg _____ x a day
2. _____; Dose ____mg _____ x a day
3. _____; Dose ____mg _____ x a day
4. _____; Dose ____mg _____ x a day
5. _____; Dose ____mg _____ x a day
6. _____; Dose ____mg _____ x a day

46. CFIDS/FM SYMPTOM CHECKLIST

a. Circle One I

CFIDS Criteria

- i. 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? Yes No
- ii. 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 six or more consecutive months of illness and must not have significantly predated the fatigue. Yes No

b. Check all that apply:

- i. ____ Impairment in short-term memory or concentration severe enough to cause substantial reduction in previous levels of personal activity?

Annapolis Integrative Medicine Chronic Fatigue/Fibromyalgia Questionnaire

- ii. ____ Sore throat?
- iii. ____ Tender neck or axillary (armpit) lymph nodes?
- iv. ____ Muscle pain?
- v. ____ Multi-joint pain without joint swelling or redness?
- vi. ____ Headaches of a new type, pattern, or severity?
- vii. ____ Unrefreshing sleep?
- viii. ____ Post-exertion fatigue lasting more than 24 hours?

c. Circle One

Fibromyalgia Criteria:

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.)

Yes No

47. 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 achiness?
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

Annapolis Integrative Medicine Chronic Fatigue/Fibromyalgia Questionnaire

1= near dead and 10= excellent

48. What is your normal blood pressure: _____/_____

49. How much do you weigh? _____ lbs; _____ kg

50. Height: _____ inches; _____ cm

51. Is your body temperature high or low (circle one)?

Please put a check mark next to the symptoms you have in each of the following categories:

52. Have you had a history of head trauma? If yes please describe incident(s) and the severity:

53. Adrenal Checklist

- a. _____ Hypoglycemia
- b. _____ Shakiness relieved with eating
- c. _____ Recurrent sore throats/infections that take a long time to go away
- d. _____ Life was very stressful before symptoms began
- e. _____ Low blood pressure
- f. _____ Dizziness on first standing
- g. _____ Have you been on Prednisone or any other corticosteroid/adrenal hormone (Medrol, Cortef) since your illness began?
If yes, did you feel better when you took it? _____

54. Thyroid Checklist

- a. _____ Weight gain? (_____ lbs over _____ years)
- b. _____ Low body temperature (under 98 degrees)
- c. _____ Achiness
- d. _____ High cholesterol

Annapolis Integrative Medicine Chronic Fatigue/Fibromyalgia Questionnaire

- e. _____ Cold intolerance
- f. _____ Heat intolerance
- g. _____ Dry skin
- h. _____ Thin hair
- i. _____ Heavy periods (Females only)
- j. _____ Rapid or erratic heart rate
- k. _____ Swollen legs
- l. _____ Enlarged tongue
- m. _____ Brittle Nails
- n. _____ Muscle tightness or cramps (especially large muscles)

TOTAL Number Yes= /14

55. Estrogen/testosterone

- a. _____ Do you have premenstrual symptoms?
- b. _____ Are you menopausal?
- c. _____ Decreased vaginal lubrication – Females only
- d. _____ Decreased erections (males only)
- e. _____ Day or night sweats or hot flashes
- f. _____ Have you had a hysterectomy, ovaries removed, or a tubal ligation?
- g. _____ Are your symptoms worse the week before your period?
- h. _____ Decreased libido?

56. Vasodepressor Syncope (NMH)

- a. _____ Dizziness or low blood pressure?
- b. _____ Did you ever have a positive Tilt Table Test?
- c. _____ Do you feel like you've been "hit by a truck" the day after exercise?
- d. _____ Constant thirst/dry mouth

57. Parasites

- a. _____ Did your problems begin with a diarrhea attack?
 - i. If so, do you remember where and when it began?
 - ii. Were you taking antibiotics before it began?
- b. _____ Do you sometimes have diarrhea? If so, is it severe? _____
- c. _____ Do you have well water?
- d. _____ Have you traveled to the tropics?
- e. _____ Do you spend time in the mountains or at lakes?

58. Essential Fatty acid deficiency

- a. _____ Do you have dry eyes?
- b. _____ Do you have dry mouth?
- c. _____ Do you have dry skin?
- d. _____ Do you have twitching of your eye lids?

59. Lyme's Disease Questions

- a. _____ History of frequent tick bites? If so, how many? _____
- b. _____ Rash after tick bite?
- c. _____ Rash that looked like a "bull's eye"?
- d. _____ Have you been treated for Lyme's disease?
- e. _____ Numbness or tingling in your fingers or feet?
- f. _____ History of a positive Lyme's Test?
- g. _____ Have you lived in areas where Lyme's or other tick-borne diseases are common?

60. Urinary Complaints:

Prostatitis (males only)

- a. _____ Burning on urination
- b. _____ Groin aching
- c. _____ Discharge from your penis (not with ejaculation), especially noticed upon waking up
- d. _____ Urine urgency with a small volume
- e. _____ Prior history of prostatitis or STD (please explain)

Women: Chronic burning when you urinate and urinary urgency even with small volumes?

Have you had urine cultures checked? _____
If yes, do they usually show infection? _____

61. Sinusitis/Nasal Congestion & Other Infections

- a. _____ Chronic nasal congestion or post nasal drip
- b. _____ Chronic yellow or green nasal discharge
- c. _____ Chronic bad taste in your mouth or bad breath
- d. _____ Headaches under or over eyes
- e. _____ Scratchy/watery eyes
- f. _____ Do you have chronic or intermittent low-grade fevers (over 99° F/ _____ °C).
- g. _____ 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? _____

62. Disordered Sleep

- a. Trouble _____ falling; _____ and/or staying asleep?
 - i. If yes, is it a ___ mild, ___ moderate, or ___ severe problem?
- b. How many hour of uninterrupted sleep do you get a night?

Annapolis Integrative Medicine Chronic Fatigue/Fibromyalgia Questionnaire

- c. _____ Do you wake up during the night? If so, how often? _____
- d. _____ Do you wake at night to urinate?
- e. _____ Do your legs jump or do you kick your spouse or kick your blankets off?
- f. _____ Do you snore? If yes:
 - i. _____ Are you more than 20 lbs overweight?
 - ii. _____ Do you have periods that you stop breathing (ask your bed partner)?
 - iii. _____ Do you have high blood pressure?

63. Vision

- a. _____ Double vision
- b. _____ Constantly changing eyeglass prescriptions
- c. _____ Blurred vision or halos around lights at night?
- d. _____ Have you had temporary vision loss in one eye?
 - i. _____ How many times? _____
 - ii. _____ How long do they last? _____
- e. _____ Dry eyes?

64. Dental

- a. _____ Dry mouth?
- b. _____ Any evidence of dental infections?
- c. _____ Metallic taste in mouth?
- d. _____ Light sensitivity or trouble focusing at night?
- e. _____ 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? _____

65. Other Problems and Questions

- a. _____ Ringing in ears
- b. _____ Hearing loss
- c. _____ Other Symptoms?

66. GI Checklist

- a. _____ Frequent diarrhea?
- b. _____ Constipation? How often do you "go"? _____
- c. _____ Do you or have you taken laxatives on a frequent basis?
- d. _____ Bloating after meals?
- e. _____ Reflux symptoms?
- f. _____ Do you take antacids, or other reflux or heartburn medications? If so which ones do you take and how often

- g. _____ Abdominal Pain? If so please describe.

Annapolis Integrative Medicine Chronic Fatigue/Fibromyalgia Questionnaire

- h. ___ Chronic Nausea and/or Vomiting?
- i. ___ Is there any blood in your bowel movements?

67. ___ Besides your illness, what other stresses are going on in your life?

68. Do you have a rash?

- a. Where is it _____
- b. What does it look like _____
- c. How long have you had it? _____
- d. Does it ___ itch, ___ burn or ___ sting?
- e. What treatments have you tried? _____

69. ___ Chest pain yes or no?

- a. How long have you had it? _____
- b. Has it been ___ getting better, ___ getting worse, ___ staying the same?
- c. With exercise (e.g., walking steps) the pain
_____ increases, ___ decreases, or ___ stays the same?
- d. With exercise do you have:
 - 1. ___ Shortness of breath
 - 2. ___ Chest tightness
 - 3. ___ Pain radiating to your left arm
- e. Can you worsen the same chest pain by pushing on your chest muscles?
- f. Are the chest pains ___ sharp, ___ dull, ___ worse with position change or deep breath?
- g. Are your chest pains mostly when you're relaxing (not exercising)? ___
- h. During the chest pains, do you have (check all that apply):
 - i. ___ Feeling of being unable to take a deep enough breath?
 - ii. ___ Numbness and/or tingling in hands and toes?
 - iii. ___ Numbness and/or tingling around the mouth?
 - iv. ___ Spacey feelings?
 - v. ___ Feeling of panic or impending death?

Annapolis Integrative Medicine Chronic Fatigue/Fibromyalgia Questionnaire

- i. Do you have high cholesterol? _____ approximately how high? _____
- j. Do you have Diabetes? _____
- k. Do you have high blood pressure? _____
- l. Recurrent palpitations? _____

70. _____ Shortness of breath?

- a. Comes and go suddenly (not with exercise)? _____
- b. Wake up short of breath at night? _____ (if yes, answer the following)
- c. Do you have ankle swelling? _____
- d. Do you get short of breath if you lay flat? _____)
 - i. If yes, how many pillows do you sleep on? _____
- e. Worse with exertion? _____
- f. How many flights of steps? _____

71. _____ Ankle swelling

If yes, does it go down when you elevate your legs? _____
Is it one leg or both? _____ If one leg which is it?
How long have you had ankle swelling? _____
Did you have trauma, surgery, or a blood clot before the swelling started? _____

72. _____ Any weight loss or gain?

If yes, _____ lb/kg, over _____ years, _____ years ago.

73. _____ Numbness or tingling around your lips or mouth?

74. _____ Panic attacks or easily startled?

75. _____ Do you have a chronic cough or cough up blood? How long has it been going on? _____

- a. Have you had a chest x-ray since this began? _____
- b. If yes, When? _____ What did it show? _____

76. _____ Pain in your:

- a. _____ Feet (check which ones apply):
 - _____ Pain by heel, worse with walking?
 - _____ Pain over the sole(s) of your feet on walking?
 - _____ Shooting/burning pain between 2 of your toes that is worse when you squeeze that area?

Annapolis Integrative Medicine Chronic Fatigue/Fibromyalgia Questionnaire

- _____ 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?

b. _____ 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?

c. _____ **Chronic anal/rectal pain?**

d. _____ **Redness and swelling in one or more joints in hands or feet?**

- _____ In one hand? _____ In one foot?
- _____ In both hands? _____ In both feet?

77. _____ Any breast lump that you have had for more than 6 weeks?

- If yes, which breast? _____
- Are you breastfeeding? _____
- Any nipple discharge? _____
- Is it, _____ milky, _____ pus, _____ bloody, _____ clear?
- Is it in, _____ right breast, _____ left breast, _____ both breasts?
- How long have you had it? _____

78. _____ Do you have chronic vulvar or vaginal pain?

- If yes: _____ Only with intercourse
- _____ Even not with intercourse

79. _____ Have you had problems with infertility?

- If yes, do you still want to have a (or another) child? _____

80. _____ When was your last period? Are they regular?

81. Any history of psychiatric illness? Please describe:

Annapolis Integrative Medicine Chronic Fatigue/Fibromyalgia Questionnaire

82. _____ Any other symptom(s) or problem(s)? (Please don't be bashful, list them all)? _____

83. _____ Did you need to change jobs or decrease how much you work because of your illness? If so, please describe:

84. _____ Do you feel depressed (as opposed to frustrated over not being able to function)?

85. _____ Do you have suicidal thoughts?

86. _____ Are your energy and mental clarity improved when you take Codeine (e.g., Darvon, Percocet, Vicoden, etc.)?

Annapolis Integrative Medicine Chronic Fatigue/Fibromyalgia Questionnaire

87. _____ 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.

YEAST QUESTIONNAIRE

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

Point Score(ADD UP AND PUT TOTAL BELOW)

- 50____ 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 shorter courses over 3 times in a twelve-month period?
- 6____ Have you ever taken an antibiotic – even for a single course?
- 25____ Have you ever had prostatitis or vaginitis?
- 5____ Have you ever been pregnant:
- 15____ Have you taken birth control pills?
- 15 ____ Have you taken corticosteroids such as Prednisone, Cortef, or Medrol
- 15____ When you are exposed to perfumes, insecticides, or other odors or chemicals, do you develop wheezing, burning eyes, or any other distress?
- 20____ 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?
- 20____ Do you crave: Sugar or Breads?
- 10____ Does tobacco smoke cause you discomfort (e.g. - wheezing, burning eyes)?

Total: _____ (CONSIDER ANTIFUNGAL TREATMENT IF 70 OR HIGHER)

Annapolis Integrative Medicine Chronic Fatigue/Fibromyalgia Questionnaire