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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?

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

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? ____

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)**

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):

____ Surgery; ____ Radiation Therapy; ____ Chemotherapy;

____ did you have other treatment? What types?

Is it active or without recurrence?

Who is treating your cancer currently?

18. ____Emphysema/COPD

19. ____Hypertension – High blood pressure

20. ____Asthma

21. ____Stomach Ulcers

22. ____Spastic Colon or Irritable Bowel Syndrome

23. ____Crohns' Disease or Ulcerative Colitis- If so, which? _____

24. ____AIDS

25. ____Polio/post-polio Syndrome

26. ____Tuberculosis

27. ____Other chronic infections? Type(s) _____

28. ____Reflex Sympathetic Dystrophy - Which extremity? _____

29. ____Recurrent Prostatitis- Has a bacterial culture ever been positive?

30. ____ Prostate enlargement

31. ____Hepatitis (check all that applies):

a. ____ Viral? ____ Hepatitis A
____ Hepatitis B
____ Hepatitis C

b. ____With infectious Mononucleosis

c. ____ Unsure

32. ____ Do you have Cirrhosis?

a. ____ Have you had a liver biopsy?
b. ____ Have you had a blood test to check for high iron levels?

33. ____ Have you had any toxic chemical exposures especially at the onset of your illness?

(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

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):

Treatment	**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 currently taking**
Rx- Elavil (Amitriptyline)	____ Helps ____ Doesn't Help ____ Don't Know if it helps	____ Yes	____ Side Effects ____ Didn't Work ____ Too expensive	____ mg; ____ x a day
Rx - Flexeril (Cyclobenzaprine)	____ Helps ____ Doesn't Help ____ Don't Know if it helps	____ Yes	____ Side Effects ____ Didn't Work ____ Too expensive	____ mg; ____ x a day
Rx - Desyrel (Trazodone)	____ Helps ____ Doesn't Help ____ Don't Know if it helps	____ Yes	____ Side Effects ____ Didn't Work ____ Too expensive	____ mg; ____ x a day
Rx – Ambien (Zolpidem)	____ Helps ____ Doesn't Help ____ Don't Know if it helps	____ Yes	____ Side Effects ____ Didn't Work ____ Too expensive	____ mg; ____ x a day
Rx – Xanax (Aprazolam)	____ Helps ____ Doesn't Help ____ Don't Know if it helps	____ Yes	____ Side Effects ____ Didn't Work ____ Too expensive	____ mg; ____ x a day
Rx – Klonopin (Clonazepam)	____ Helps ____ Doesn't Help ____ Don't Know if it helps	____ Yes	____ Side Effects ____ Didn't Work ____ Too expensive	____ mg; ____ x a day
Rx – Soma (Carisprodol)	____ Helps ____ Doesn't Help ____ Don't Know if it helps	____ Yes	____ Side Effects ____ Didn't Work ____ Too expensive	____ mg; ____ x a day
Rx - Armour Thyroid	____ Helps ____ Doesn't Help ____ Don't Know if it helps	____ Yes	____ Side Effects ____ Didn't Work ____ Too expensive	____ mg; ____ x a day
Rx - Synthroid	____ Helps ____ Doesn't Help ____ Don't Know if it helps	____ Yes	____ Side Effects ____ Didn't Work ____ Too expensive	____ mg; ____ x a day
Rx - Cortef	____ Helps ____ Doesn't Help ____ Don't Know if it helps	____ Yes	____ Side Effects ____ Didn't Work ____ Too expensive	____ mg; ____ x a day
Rx- Florinef (Fludrocortisone)	____ Helps ____ Doesn't Help ____ Don't Know if it helps	____ Yes	____ Side Effects ____ Didn't Work ____ Too expensive	____ mg; ____ x a day

Natural Estrogen/Biest Brand Name _____	____ Helps ____ Doesn't Help ____ Don't Know if it helps	____ Yes	____ Side Effects ____ Didn't Work ____ Too expensive	____ mg; ____ x a day ____ every day ____ days per month
Rx - Other Estrogen Replacement Brand Name _____	____ Helps ____ Doesn't Help ____ Don't Know if it helps	____ Yes	____ Side Effects ____ Didn't Work ____ Too expensive	____ mg; ____ x a day
Rx - Birth control pills Brand Name _____	____ Helps ____ Doesn't Help ____ Don't Know if it helps	____ Yes	____ Side Effects ____ Didn't Work ____ Too expensive	____ mg; ____ x a day
Rx - Natural Progesterone	____ Helps ____ Doesn't Help ____ Don't Know if it helps	____ Yes	____ Side Effects ____ Didn't Work ____ Too expensive	____ mg; ____ x a day ____ every day ____ days per month
Rx - Testosterone Brand Name _____	____ Helps ____ Doesn't Help ____ Don't Know if it helps	____ Yes	____ Side Effects ____ Didn't Work ____ Too expensive	____ mg; ____ x a day ____ every day ____ days per month
Rx - Nystatin	____ Helps ____ Doesn't Help ____ Don't Know if it helps	____ Yes	____ Side Effects ____ Didn't Work ____ Too expensive	____ mg; ____ x a day
Diflucan **Sporanox** **Lamisil**	____ Helps ____ Doesn't Help ____ Don't Know if it helps	____ Yes	____ Side Effects ____ Didn't Work ____ Too expensive	____ mg; ____ x a day
Rx – Flagyl (Metranidazole)	____ Helps ____ Doesn't Help ____ Don't Know if it helps	____ Yes	____ Side Effects ____ Didn't Work ____ Too expensive	____ mg; ____ x a day
Rx – Yodoxin (Iodoquinol)	____ Helps ____ Doesn't Help ____ Don't Know if it helps	____ Yes	____ Side Effects ____ Didn't Work ____ Too expensive	____ mg; ____ x a day
Rx – Doxycycline (Tetracycline)	____ Helps ____ Doesn't Help ____ Don't Know if it helps	____ Yes	____ Side Effects ____ Didn't Work ____ Too expensive	____ mg; ____ x a day
Rx - Cipro (Ciprofloxacin)	____ Helps ____ Doesn't Help ____ Don't Know if it helps	____ Yes	____ Side Effects ____ Didn't Work ____ Too expensive	____ mg; ____ x a day
Rx – Zoloft (Sertraline)	____ Helps ____ Doesn't Help ____ Don't Know if it helps	____ Yes	____ Side Effects ____ Didn't Work ____ Too expensive	____ mg; ____ x a day
Rx – Paxil (Paroxetine)	____ Helps ____ Doesn't Help ____ Don't Know if it helps	____ Yes	____ Side Effects ____ Didn't Work ____ Too expensive	____ mg; ____ x a day
Rx – Prozac (Fluoxetine)	____ Helps ____ Doesn't Help ____ Don't Know if it helps	____ Yes	____ Side Effects ____ Didn't Work ____ Too expensive	____ mg; ____ x a day
Rx – Effexor (Venlafaxine)	____ Helps ____ Doesn't Help ____ Don't Know if it helps	____ Yes	____ Side Effects ____ Didn't Work ____ Too expensive	____ mg; ____ x a day
Rx – Cymbalta	____ Helps	____ Yes	____ Side Effects	

(Duloxetine)	____ Doesn't Help ____ Don't Know if it helps		____ 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
Lyrica	____ 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	____ 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? Please list all medications including ones noted above:

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/Supplements

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
11. _____; 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?

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
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
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?
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.
_____
_____
_____

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?

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?
_____ 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:

_____
_____
_____

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.)?

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)