

**Annapolis Integrative Medicine Chronic Fatigue/Fibromyalgia Questionnaire**

**Alan S Weiss MD  
Annapolis Integrative Medicine  
1819 Bay Ridge Ave  
Suite 180  
Annapolis, MD 21403**

[AnnapolisIntegrativeMedicine.com](http://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**

- 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>	<b>Check if you are currently taking</b>	<b>Check if you took in the past and stopped</b>	<b>If you discontinued the treatment give the single main reason</b>	<b>Dose you are <u>currently</u> taking</b>
<b>Rx- Elavil (Amitriptyline)</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 - Flexeril (Cyclobenzaprine)</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 - Desyrel (Trazodone)</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 – Ambien (Zolpidem)</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 – Xanax (Aprazolam)</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 – Klonopin (Clonazepam)</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 – Soma (Carisprodol)</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 - Armour Thyroid</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 - Synthroid</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 - Cortef</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- Florinef (Fludrocortisone)</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

**Annapolis Integrative Medicine Chronic Fatigue/Fibromyalgia Questionnaire**

<b>Natural Estrogen/Biest</b> 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
<b>Rx - Other Estrogen Replacement</b> 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
<b>Rx - Birth control pills</b> 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
<b>Rx - Natural Progesterone</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	<input type="checkbox"/> mg; <input type="checkbox"/> x a day <input type="checkbox"/> every day <input type="checkbox"/> days per month
<b>Rx - Testosterone</b> 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
<b>Rx - Nystatin</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	<input type="checkbox"/> mg; <input type="checkbox"/> x a day
<b>Diflucan Sporanox Lamisil</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	<input type="checkbox"/> mg; <input type="checkbox"/> x a day
<b>Rx – Flagyl (Metranidazole)</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	<input type="checkbox"/> mg; <input type="checkbox"/> 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	<input type="checkbox"/> mg; <input type="checkbox"/> 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	<input type="checkbox"/> mg; <input type="checkbox"/> 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	<input type="checkbox"/> mg; <input type="checkbox"/> 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	<input type="checkbox"/> mg; <input type="checkbox"/> 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	<input type="checkbox"/> mg; <input type="checkbox"/> 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	<input type="checkbox"/> mg; <input type="checkbox"/> 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	<input type="checkbox"/> mg; <input type="checkbox"/> x a day
<b>Rx – Cymbalta</b>	<input type="checkbox"/> Helps	<input type="checkbox"/> Yes	<input type="checkbox"/> Side Effects	

**Annapolis Integrative Medicine Chronic Fatigue/Fibromyalgia Questionnaire**

<b>(Duloxetine)</b>	<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	___ 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	___ 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	___ 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	___ Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too expensive	___ mg; ___ x a day
<b>Lyrica</b>	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't Help <input type="checkbox"/> Don't Know if it helps	___ 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	___ 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	___ Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too expensive	___ mg; ___ x a day
<b>Vitamin B12</b> <input type="checkbox"/> injections <input type="checkbox"/> sublingual	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't Help <input type="checkbox"/> Don't Know if it helps	___ Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too expensive	___ mcg; ___ 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	___ 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	___ Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too expensive	___ mg; ___ x a day
<b>L-Lysine</b>	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't Help <input type="checkbox"/> Don't Know if it helps	___ Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> Too expensive	___ mg; ___ x a day
<b>Magnesium</b>	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn't Help <input type="checkbox"/> Don't Know if it helps	___ 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	___ Yes	<input type="checkbox"/> Side Effects <input type="checkbox"/> Didn't Work <input type="checkbox"/> 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

**Annapolis Integrative Medicine Chronic Fatigue/Fibromyalgia Questionnaire**

**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?

**Annapolis Integrative Medicine Chronic Fatigue/Fibromyalgia Questionnaire**

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**

**Annapolis Integrative Medicine Chronic Fatigue/Fibromyalgia Questionnaire**

- 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

**Annapolis Integrative Medicine Chronic Fatigue/Fibromyalgia Questionnaire**

---

---

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?

**Annapolis Integrative Medicine Chronic Fatigue/Fibromyalgia Questionnaire**

- 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):

**Annapolis Integrative Medicine Chronic Fatigue/Fibromyalgia Questionnaire**

- \_\_\_\_\_ 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?**

*Annapolis Integrative Medicine Chronic Fatigue/Fibromyalgia Questionnaire*

**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.)?**

**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***