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Name ______________________________________________ Date ____________________

E-mail ____________________________ Home Phone (____)__________________________

Cell Phone (____) _____________________Work Phone (____) __________________________

What country do you live in? ___________________________________________________

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

_______________________________________________________________________________

_______________________________________________________________________________

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

_______________________________________________________________________________

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

______ Fibromyalgia Date ____________ Physician Name ______________________
______ Chronic Fatigue Syndrome Date ____________ Physician Name ______________________
______ Lyme disease Date ____________ Physician Name ______________________

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

_______________________________________________________________________________

7. How many children do you have __________ Ages & names ______________________________

_______________________________________________________________________________

8. Are you: married, single, separated, divorced, widowed (circle one)
9. How many hours a week were you working (including commute) at the onset of your illness ______________;

How many hours spent weekly on your children’s care of care of your family at onset ____________________

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

10. Occupation ____________________________________________________________

11. Do you have family members with Fibromyalgia/Chronic Fatigue Syndrome or Lyme _____Yes _____ No

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

_______________________________________________________________________________

12. How old are you? _______________ Date of birth? __________________ Female ________ Male ________

13. How many doctors have you seen for your symptoms ____________________________________________

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

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

_____ Stroke(s) Approx. year _________
_____ Multiple Sclerosis Approx. year _________
_____ Neuropathies – If so, what type___________ Approx. year _________
_____ Glaucoma Approx. year _________
_____ Cataracts Approx. year _________
_____ Lupus Approx. year _________
_____ Rheumatoid Arthritis Approx. year _________
_____ Osteo Arthritis ("wear & tear" arthritis) Approx. year _________
_____ Scleroderma Approx. year _________

**_____ Other Rheumatoid Diseases**

List them:

__________________ Approx. year _________
__________________ Approx. year _________
__________________ Approx. year _________

_____ Phlebitis and/or Pulmonary Embolus Approx. year _________

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

**_____ Angina or heart attack (Myocardial Infarction)**

_____ Angina; _____ Heart attack; _____ Both

1) Was this confirmed by -

_____ EKG and/or
_____ Exercise stress test and/or
_____ Heart catheterization

2) Did you have: _______ Angioplasty and/or Bypass ______ If so, when? ____________

_____ Mitral Valve Prolapse
_____ Heart valve disease? Which Disease ____________________________________________

**_____ Are you on blood thinners**

If so, check which one and fill in dose:

_____ Coumadin/Warfarin Dose _____ mg per day
_____ Heparin Dose _____ mg per day
_____ Aspirin Dose _____ mg per day
_____ Other Dose _____ mg per day

_____ Diagnosis of abnormal heart rhythm(s)? Type ___________________________________________

***_____ Cancer? (check all that apply):***

______ **Breast**; date of diagnosis_____________________________________________________

If yes – Metastic/Nonmetastic ___________________, to where _________________________

Did you have (check all that apply):

_________________ Surgery; _____________ Radiation Therapy; __________ chemotherapy;

Other treatment? What types ____________________________________________________

Is it active or without recurrence _________________________________________________

______ **Prostate (males only)**; date of diagnosis ________________________________________

If yes – Metastic/Nonmetastic _________________, to where ___________________________

Did you have (check all that apply):

_________________ Surgery; _____________ Radiation Therapy; __________ chemotherapy;

Other treatment? What types _ ___________________________________________________

Is it active or without recurrence ________________________________________________

______**Uterine (female only)**; date of diagnosis _________________________________________

If yes – Metastic/Nonmetastic _________________, to where ___________________________

Did you have (check all that apply):

_________________ Surgery; _____________ Radiation Therapy; __________ chemotherapy;

Other treatment? What types ____________________________________________________

Is it active or without recurrence ________________________________________________

_____ **Ovarian (female only)**; date of diagnosis _______________________________________

If yes – Metastic/Nonmetastic _________________, to where ___________________________

Did you have (check all that apply):

_________________ Surgery; _____________ Radiation Therapy; __________ chemotherapy;

Other treatment? What types ____________________________________________________

Is it active or without recurrence ________________________________________________

____ **Other types**? Which? ______________________ Date of diagnosis____________________

If yes – Metastic/Nonmetastic _________________, to where ___________________________

Did you have (check all that apply):

_________________ Surgery; _____________ Radiation Therapy; __________ chemotherapy;

Other treatment? What types ____________________________________________________

Is it active or without recurrence ________________________________________________

Is there still evidence of the cancer being present ____________________________________

Has it spread from its original site? _____; If yes, to where _____________________________

______ Emphysema

______ Hypertension - High blood pressure

______ Asthma

______ Stomach Ulcers

______ Spastic Colon or Irritable Bowel Syndrome

______ Crohn's Disease or Ulcerative colitis – If so, which? _________________________________________

______ AIDS

______ Polio

______ Tuberculosis

______ Other chronic infections? Type(s) ______________________________________________________

______ Reflex Sympathetic Dystrophy (RCPS) – Which extremity? _____________________________________

______ Recurrent Prostatitis – Has a bacterial culture ever been positive? _____________________________

______ Prostate enlargement

______ Kidney stones

______ Active disc Disease (e.g., sciatica)

______ Kidney failure

______ Other kidney problems? Describe ______________________________________________________

_____ **Hepatitis (check all that apply):**

_____ Viral? _____ Hepatitis A

_____ Hepatitis B

_____ Hepatitis C

_____ With infectious Mono

_____ Any toxic chemical exposures? If yes, list what exposures and when: ____________________

____________________________________________________________

_____ Lupus

_____ Alcoholic

_____ Other types of Hepatitis? Which ____________________________________________

_____ Unknown cause

Are you using herbs______ List: ____________________________________________

_____ Do you have Cirrhosis _____ I don't know.

_____ Have you had a liver biopsy

_____ Have you had a blood test to check for high iron levels

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

_____ Juvenile onset

_____ Adult onset

_____ Are you taking tablets of Niacin containing over 1000mg per day

_____ **Pancreatitis**

If yes, from

_____ Gallstones

_____ Alcohol

_____ Other known cause (list) ____________________________________________

_____ Unknown cause

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

Year (approx) ______________ Type of surgery ______________________________

Year (approx) ______________ Type of surgery ______________________________

Year (approx) ______________ Type of surgery ______________________________

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

Year (approx) ______________ Reason ______________________________

Year (approx) ______________ Reason ______________________________

Year (approx) ______________ Reason ______________________________

18. What other diagnoses do you have ____________________________________________

____________________________________________________________

**19. What medications are you allergic to ____________________________________________**

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

____________________________________________________________

20. Does your insurance pay for medications ______ yes; _____ no

If yes: what % ______; is there a co-pay________; is there a limit per year:__________

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

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

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

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

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

Prescription or Supplement:

- ________________; Dose ______ mg ______ x a day _____________________________outcome
- ________________; Dose ______ mg ______ x a day _____________________________outcome
- ________________; Dose ______ mg ______ x a day _____________________________outcome
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- ________________; Dose ______ mg ______ x a day _____________________________outcome

What other treatment(s) **are** you on Continued
Prescription or Supplement

- ________________; Dose ______ mg ______ x a day _____________________________outcome
- ________________; Dose ______ mg ______ x a day _____________________________outcome
- ________________; Dose ______ mg ______ x a day _____________________________outcome
- ________________; Dose ______ mg ______ x a day _____________________________outcome
- ________________; Dose ______ mg ______ x a day _____________________________outcome
- ________________; Dose ______ mg ______ x a day _____________________________outcome

What Treatments Have you been on:

- ________________; Dose ______ mg ______ x a day _____________________________outcome
- ________________; Dose ______ mg ______ x a day _____________________________outcome
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**Comments:**

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

__________________________________________________________________________

## SYMPTOM CHECKLIST

**CFIDS Cineraria** (circle one)

1. Yes____ No____ Has your fatigue not been lifelong (i.e., you weren't born severely tired); and not the result of ongoing exertion; and not substantially alleviated by rest; and results in substantial reduction in previous levels of occupational, educational, social, or personal activities?
2. Yes____ No ____ Do you have four or more of the following eight symptoms (please check the letter(s) of all that apply? All of which must have persisted or recurred during the six or more consecutive months of illness and must not have significantly predated the fatigue.

______ A. Impairment in short-term memory or concentration severe enough to cause substantial reduction in previous levels of personal activity
______ B. Sore throat
______ C. Tender neck or axillary (armpit) lymph nodes
______ D. Muscle pain
______ E. Multijoint pain without joint swelling or redness
______ F. Headaches of new type, pattern, or severity
______ G. Unrefreshing sleep
______ H. Post-exertional fatigue lasting more than 24 hours

**Fibromyalgia Criteria** (circle one)

1. Yes____ No____ Have you had chronic widespread pain for more than three months in all four quadrants of the body (i.e., above and below the waist and on both sides of the body) and also axial pain (i.e., headache or pain around the spine or chest)? (These don't all have to be at the same time).
2. Pleas rate the following on a scale of 1 (near dead) to 10 (excellent) (circle the number that applies):

A. How is your energy?
1 2 3 4 5 6 7 8 9 10
1 = near dead and 10 = excellent

B. How is your sleep?
1 2 3 4 5 6 7 8 9 10
1 = no sleep and 10 = 8 hours of sleep a night without waking

C. How is your mental clarity?
1 2 3 4 5 6 7 8 9 10
1 = brain dead and 10 = good clarity

D. How bad is your achy-ness?
1 2 3 4 5 6 7 8 9 10
1 = very severe pain and 10 = pain free

E. How is your overall sense of well-being?
1 2 3 4 5 6 7 8 9 10
1 = near dead and 10 = excellent

**Physical Information**

1. Give a representative blood pressure: ___________________________________
2. How much do you weigh? ______________________lbs; ___________________kg
3. Height: _________________ inches; ________________ cm

4. What are your average temperatures (oral – 11AM to 7PM)? ___________degrees

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

**Adrenal Checklist**

_____ Hypoglycemia
_____ Shakiness relieved with eating
_____ Moodiness
_____ Recurrent infections that take a long time to go away
_____ Life was very stressful before symptoms began
_____ Low blood pressure
_____ Dizziness on first standing
_____ Sugar cravings
_____ Food sensitivity (if yes, please list foods)
_____ Have you been on Prednisone (Cortisone)
If yes, for how long ______________
Did you feel better when you took it _______________
If yes, did you take it: _____ after your illness began
_____ before your illness began
_____ both
What dose & form of Cortisone/Prednisone did you take ________________________

**Thyroid Checklist**

_____ Have you had weight gain? If yes/how many pounds _____ lbs over what period of time_________
_____ Low body temperature (under 98 degrees)
_____ Achiness
_____ High cholesterol
_____ Cold intolerance
_____ Dry skin
_____ Thin hair
_____ Heavy periods – **Females only**

**Other Hormones**

_____ Do you have premenstrual symptoms? **Females only** (describe) ___________________________
_____ Are you menopausal? **(Females only)** If yes, when did your periods stop? _____ years ago.
_____ Pallor (pale face) and cold extremities
_____ Irregular periods – **Females only**
_____ Decreased arm and leg hair growth
_____ Decreased vaginal lubrication – **Females only**
_____ Delayed orgasm
_____ Decreased erections **(Males only)**
_____ Day or night sweats or hot flashes
_____ Any nipple discharge
_____ One breast _____ Both breasts

**Females only** – Have you had:

1) A hysterectomy ______ If yes, how long ago ________________
2) Ovaries removed ______ *(circle)* One Both If yes, how long ago ________________
3) A tubal ligation ______ If yes, how long ago ________________

______ Are your symptoms worse the week before your period? **(Females only)**
______ Decreased libido

**Vasodepressor Syncope (NMH)**

______ Disequilibrium
______ Did you ever have a Tilt Table Test
If yes, was it ______ positive ______ normal
______ Do you feel like you've been "hit by a truck" the day after exercise

**Prostatitis (males only)**

______ Burning on urination
______ Groin aching
______ Discharge from your penis (not with ejaculation)
______ Urine urgency with a small volume

**Sinusitis/Nasal congestion & Other Infections**

______ Chronic nasal congestion or post nasal drip
______ Chronic yellow or green nasal discharge
______ Chronic bad taste in your mouth or bad breath
______ Headaches under or over eyes
______ Scratchy/watery eyes
______ Do you have chronic or intermittent low-grade fevers (over 99º F/ ______ºC).
1, If yes, how high does the fever go ______
2. Did your illness begin with a fever ______
3. Do you have lung congestion ______
4. How often do you have the fever ______
______ Has any antibiotic you've been on in the past even temporarily improved your Chronic Fatigue/fibromyalgia symptoms
If yes, which __________________
How long did you take it _________________

**Disordered Sleep**

______ Trouble ______ falling ______ staying asleep? If yes, is it ____ mild, ____ moderate, or ____ severe.
______ How many hours of uninterrupted sleep do you get a night ____________________
______ Do you wake up during the night? If so, how often _______________________
______ Do you wake at night to urinate
______ Do your legs jump a lot or do you kick your spouse or kick your blankets off at night
______ Do you snore? If yes:
____ 1) Are you more than 20lbs overweight
____ 2) Do you have periods that you stop breathing (ask your bed partner)
____ 3) Do you have high blood pressure

**Yeast Overgrowth**

______ Recurrent vaginal yeast infections **(females)**. If so, how often ____________

______ Toenail or fingernail fungal changes

______ Skin fungal infections (i.e., athlete's foot, jock itch, rash under bra)

______ Do you get in the mouth sores frequently (not on lips)

______ Do you get cold sores or Herpes attacks before or during symptom flares that seems to flare your symptoms

______ Been on birth control pills

If yes, how did you feel on them? ______ better; ______ worse; ______ no change

______ Small amounts of alcohol aggravate symptoms

**Parasites**

______ did your problems begin with a diarrhea attack

______ Do you sometimes have diarrhea? If so, is it severe ______

______ Do you sometimes have constipation

______ Do you have well water

**Vision/Dental**

______ Double vision

______ Constantly changing eyeglass prescriptions

______ Blurred vision or halos around lights at night

______ Have you had temporary vision loss in one eye

Which one ______

How many times ______

Is your sedimentation (sed) rate blood test over 30 ______

______ Dry eyes

______ Dry mouth

______ Any evidence of dental infections

______ Metallic taste in mouth

______ Light sensitivity or trouble focusing at night

**Other Problems and Questions**

______ Do you drink non-diet sodas or other sweetened drinks? If so, how much? ______ ounces a day

______ Do you drink coffee?

If so, how many 8oz. (American)/240cc (Metric) cups a day? Regular ______ Decaf ______

______ Do you drink alcohol? If so, how many drinks per day on average? __________________________

______ Do you smoke cigarettes? If yes, ______ packs a day

______ How much can you exercise? ________________________________________________________

______ Besides your illness, what other stresses are going on in your life? __________________________

______________________________________________________________________________

______ Do you have frequent and persistent infections? If yes, what kind? __________________________

______ A rash? What does it look like? ______________________________________________________

How long have you had it? __________________

Does it ______ itch, ______ burn or ______ sting?

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

_____ Chest pain

How long have you had it ________________________

Has it been _____ getting better, _____ getting worse, _____ staying the same

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

_____ increases, _____ decreases, or _____ stays the same

With exercise do you have:

_____ shortness of breath

_____ chest tightness

_____ pain radiating to your left arm

_____ sweating

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

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

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

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

_____ Feeling of being unable to take a deep enough breath

_____ Numbness and/or tingling in hands and toes

_____ Numbness and/or tingling around the mouth

_____ Spacey feelings

_____ Feeling of panic or impeding death

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

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

If yes, did they have it before age 65 _____

Do you have high cholesterol _____ Approximately how high _____

Do you have Diabetes _____

Do you have high blood pressure _____

Recurrent palpitations _____

Palpitations last over 20 seconds _____

Pulse _____ regular or _____ irregular

Pulse over 120/minutes _____

Get dizzy with palpitations _____

Take Thyroid hormones _____

_____ Shortness of breath

Comes and go suddenly (not with exercise) _____

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

Do you have ankle swelling _____

Do you get short of breath if you lay flat _____

If yes, how many pillows do you sleep on _____

Worse with exertion _____

How many flights of steps _____

_____ Transient weakness/paralysis in one arm and/or leg

Is it always on the same

_____ Ankle swelling

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

_____ Numbness or tingling around your lips or mouth

_____ Blood in your stool

Is it only bright red blood on your toilet tissue or on stool (not mixed in) ___________________

If yes, do you have Hemorrhoids _____

If no, answer the following:

Is the blood mixed in (not only on) your stool _____

Do you have bloody mucus with stools _____ How often _____

Do you have painful bowel movements _____

Has your doctor done:

| When | | Result/Diagnoses |
|---|---|---|
| _____ | a colonoscopy | _____ |
| _____ | a Sigmoidoscopy | _____ |
| _____ | a Barium Enema | _____ |
| _____ | none of these | _____ |

Have your bowel movements gotten thinner (e.g., pencil like) _____

Have you had a lot of:

_____ constipation

_____ diarrhea

_____ both

_____ neither

_____ Cough up blood? How long has it been going on __________________________________________

Have you had a chest x-ray since this began _____

If yes, when? ___________ what did it show _______________________________________

_____ Frequently cough up yellow mucus

Have you had a chest x-ray since this began _____

If yes, when? ___________ what did it show _______________________________________

_____ Chronic cough? If yes, for how long _____

Have you had a chest x-ray since this began _____

If yes, when? ___________ what did it show _______________________________________

_____ Chronic burning when you urinate and urinary urgency even with small volumes

Have you had urine cultures checked _____

If no, check urine culture during symptoms.

If yes, do they usually show infection _____

If no:

Male – do you have discharge from your penis when you wake in the morning _____

Female – Is this a severe problem? _____ If no – take no action

_____ Chronic anal/rectal pain

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

If yes, which breast _________________

Are you breastfeeding? If yes – skip to next question

Is it, _____ milky, _____ pus, _____ bloody, _____ clear

Is it in, _____ right breast, _____ left breast, _____ both breasts

How long have you had it? ________________________________________________

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

# YEAST QUESTIONNAIRE

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

## SECTION A: YOUR MEDICAL HISTORY

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

Total ______

## SECTION B: MAJOR SYMPTOMS

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

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

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

**Section C: Other Symptoms**

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

| | |
|---|---|
| If a symptom is occasional or mild | Score 1 point |
| If a symptom is frequent and/or moderately severe | Score 2 points |
| If a symptom is severe and/or persistent | Score 3 points |

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

## Lyme Disease and Associated Infections

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

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

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

## Please check any of the Following that Apply

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

______ Burning or stabbing sensations / Shooting pains
______ Disturbed sleep: too much, too little, fractionated, early awakening
______ Confusion and/or difficulty thinking, writing, forgetfulness
______ Difficulty with concentration, reading, speaking, absorbing new information. . .
______ Speech errors or speak the wrong words
______ Disorientation and getting lost
______ Increased motion sickness, vertigo or spinning
______ Poor short-term memory
______ Inability to recognize and/or name common items, such as tooth brush, can opener. . . . .
______ Panic attacks / anxiety
______ Irritability
______ Psychosis
______ Depression
______ Rapid mood swings
______ Numbness
______ Facial paralysis – Bell's Palsy
______ Tingling
______ Light or sound sensitivity
______ Tremor and/or seizures
______ Ringing in ears
______ Hearing loss
______ Light or sound sensitivity
______ Skin hypersensitivity
______ Twitching of the face or other muscles
______ Sexual dysfunction or loss of libido
______ Pelvic pain
______ Testicular pain
______ Unexplained breast pain
______ Unexplained menstrual irregularity'
______ Unexplained milk production
______ Do you have chronic vulvar or vaginal pain? **(For females only)**

If yes: ______ Only with intercourse

______ Even not with intercourse

______ Heart palpitations
______ Pulse skips
______ Pain in your Feet (check all that apply):

______ Pain by heel, worse with walking
______ Pain over most of the sole(s) of your feet on walking
______ Shooting/burning pain between 2 of your toes that is worse when you squeeze that area
______ Horrible pain in one foot (whole foot – not only one joint) that's been occurring for more than 6 weeks and makes you want to be sure no one touches it

______ Does the foot often feel cooler or warmer to the touch than the other and looks either pale or red
______ Did you have an injury or surgery to this foot or the hip on the same side before the pain began

_____ Pain in your Hands (check all that apply)

_____ Horrible pain in one hand (whole hand – not only one joint) that's been occurring for more than 6 weeks and makes you want to be sure no one touches it

_____ Does the hand often feel cooler or warmer to the touch than the other and looks either pale or red

_____ Did you have an injury or surgery to this hand or the shoulder on the same side before the pain began

_____ Redness and swelling in one or more joints in hands or feet

_____ In one hand _____ In one foot

_____ In both hands _____ In both feet

If yes, do you have a history of:

_____ Gout

_____ Rheumatoid Arthritis

_____ Other Arthritis, please specify ___________________________________

## Co Infections - Please Check all that Apply

**Babesiosis**

___ Fever
___ Shaking chills
___ Cough
___ Imbalance
___ Dark urine/blood in urine
___ Anemia
___ Malaise
___ Sweats
___ Increased sense Déjà vu
___ Night sweats
___ Headaches
___ Air hunger
___ Weakness/Fatigue
___ Abdominal Pain
___ Nausea
___ Diarrhea
___ Neck/back stiffness

**Bartonella**

___ Depression
___ Stomach pain
___ Pain on soles of feet
___ Muscle Twitching
___ Dementia
___ Abdominal Pain
___ Myalgias
___ Combative behavior
___ Flu-like malaise
___ Headaches
___ Anemia
___ High Fever
___ Immune deficiency
___ Jaundice
___ Sore Throat
___ Raised reddish/purple rash

**Ehrlichia**

___ Headaches
___ Myalgias
___ Ongoing fatigue
___ Nose bleeds
___ Decrease white blood cell count
___ Low platelets in blood
___ Bleeding gums
___ Bruising
___ Purpura Red.purple rash Under skin on Forearm