Chronic Fatigue/Fibromyalgia SYMPTOM CHECKLIST

Circle One I. CFIDS Criteria

1. A. 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? ,

B. 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 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 a new type, pattern, or severity?
____ G. Unrefreshing sleep?
____ H. Post-exertional fatigue lasting more than 24 hours?

Circle One II. Fibromyalgia Criteria

2. 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.)

3. 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

4. What are your average temperatures (oral - 11AM to 7PM)? _____degrees
If you will not be seen for a few days, please also measure your morning temperature, before you are up and

moving around, for 5 days: _____ _____ _____ _____ _____
Day 1 Day 2 Day 3 Day 4 Day 5

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

_____ Weight gain? (_____ lbs or _____ kg - over _____ years)
_____ Low body temperature (under 98 degrees)
_____ Achiness
_____ High cholesterol
_____ Cold intolerance (i.e. you feel cold when other people are comfortable)
____ 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? __ yrs 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? ____ One, ____ Both; How long ago?_____
3) A tubal ligation? ____ How long ago? _____
_____ Are your symptoms worse the week before your period? **(Females Only)**
_____ Decreased libido?

Vasodepressor Syncope (NMH)

_____ Dysequilibrium / Feeling off-balance or dizzy

_____ Did you ever have a Tilt Table Test?

If yes, was it ____ positive

____ normal

Postexertional Fatigue

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

Lyme's

_____ History of frequent tick bites? If so, how many? _____

_____ Rash after tick bite?

_____ Rash that looked like a "bull's eye"?

_____ Have you been treated for Lyme's disease?

_____ Numbness or tingling in your fingers or feet?

_____ History of a positive Lymes Test?

Prostatitis (males only)

_____ Burning on urination

_____ Groin aching

_____ Discharge from your penis (not with ejaculation)

_____ Urine urgency with a small volume

Sinusitis/Nasal Congestion & Other Infections

_____ Chronic nasal congestion or post nasal drip

_____ Chronic yellow or green nasal discharge

_____ Chronic bad taste in your mouth or bad breath

_____ Headaches under or over eyes

_____ Scratchy/watery eyes

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

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; ____ and/or staying asleep? If yes, is it a ___ mild, ___ moderate, or ___ severe problem?

_____ How many hour 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 alot 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 <u>in the mouth</u> sores frequently (not on lips)?

_____ Do you get cold sores or Herpes attacks before or during symptom flares that seen to flare your symptoms?

_____ Been on birth control pills?
If yes, how did you feel on them? ___ better; ___ worse; ___ no change
_____ Do 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? _____
How long do they last? _____
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

_____ Ringing in ears
_____ Hearing loss
_____ Do you drink non-diet sodas or other sweetened drinks? If so, how much? ____ ounces a day.
_____ Do you drink "diet" or artificially sweetened beverages?
_____ 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?
_____ Any unusual weight gain or loss? If yes, _____ lb/kg, over _____ years, _____ years ago. Describe what happened:_____
_____ Numbness or tingling around your lips or mouth?
_____ 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

_____ Does food often stick in your foodpipe?
How long has this been going on? _____
Is it worse for _____ solids, _____liquids, ____ the same for both?
Do you have a history of drinking over 2 alcoholic drinks/day on average? _____
Have you used tobacco for over 12 years? _____

_____ 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 tastebuds sometimes become inflamed and painful? _____

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

_____

_____

_____

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

_____ Did your symptoms begin soon or immediately after:

____ pregnancy
____ an accident? If so, how soon? _____
If accident, give details _____
____ after a vaccination
____ moving into a new home
____ an infection. Give details: _____

_____ Besides those already discussed:

A. what substances or treatments have you found helpful in the past? _____

_____

_____

B. what substances or treatments have you tried without benefit? _____

_____

_____

C. what substances or treatments have made you feel worse in the past? _____

_____

_____

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 provider may find helpful. You may use the back of this page as well.