Chronic Fatigue Syndrome / Fibromyalgia Short-Form Questionnaire

Name _____ Date _____

Please describe briefly (in one sentence) what your main problem(s) are:

1. Did symptoms begin ____ suddenly or ____ gradually?
2. What stresses were occurring in your life when the disease began?
3. Did the illness begin soon after ___ A childbirth?; ____ An injury? ____ A Cipro family antibiotic? ____ Taking cholesterol medications (called statins)?
4. Check any of these that you have or have had:

   ☐ Multiple Sclerosis
   ☐ Glaucoma or Cataracts
   ☐ Chest pain
   ☐ Do you feel depressed (as opposed to frustrated)?
   ☐ Autoimmune illness (e.g., Lupus, Rheumatoid Arthritis). If yes, list below:

Please Check the Symptoms You Have:

THYROID CHECKLIST:

☐ 5. Weight gain (_____ lbs over _____ years)
☐ 6. Cold intolerance
☐ 7. Low body temperature (under 98 degrees)
☐ 8. High cholesterol
☐ 9. Achiness
☐ 10. Dry skin
☐ 11. Thin hair
☐ 12. Heavy periods **(females only)**

ADRENAL CHECKLIST:

- ☐ 13. Shakiness or irritability relieved with eating
- ☐ 14. Recurrent sore throats/infections that take a long time to go away
- ☐ 15. Life was very stressful before symptoms began
- ☐ 16. Have you been on Prednisone since your illness began (Cortisone)? If yes, did you feel better when you took it? _____

ESTROGEN/PROGESTERONE (WOMEN ONLY):

- ☐ 17. Do you have premenstrual symptoms?
- ☐ 18. Have you had a hysterectomy, ovaries removed, or a tubal ligation?
  When? _____
- ☐ 19. Are your symptoms worse the week before your period?
- ☐ 20. Decreased vaginal lubrication **(females only)**
- ☐ 21. Day or night sweats or hot flashes
- ☐ 22. Are you menopausal?
- ☐ 23. Decreased libido

TESTOSTERONE (MEN ONLY):

- ☐ 24. Decreased libido
- ☐ 25. Decreased erections
- ☐ 26. High blood pressure or high cholesterol (or on medication for these)

DISORDERED SLEEP:

- ☐ 27. Trouble falling and/or staying sleep. If yes, check severity below.
  ☐ Mild ☐ Moderate ☐ Severe
- ☐ 28. Do your legs jump a lot at night?
- ☐ 29. Do you snore? If yes:
  - ☐ 1) Do you fall asleep easily during the day (e.g., driving or watching TV)?
  - ☐ 2) Do you have periods that you stop breathing during sleep?
  - ☐ 3) Do you have high blood pressure?
  - ☐ 4) Are you more than 20lbs overweight?
  - ☐ 5) Shirt collar size of 17 inches or larger?

YEAST QUESTIONNAIRE:

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

30. Point Score (Add Points Checked Off and Enter Total Below)

(50 pts) ☐ Have you been treated for acne with tetracycline, erythromycin, or any other antibiotic for one month or longer?

(50 pts) ☐ 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?

(50 pts) ☐ Do you have spastic colon or Irritable Bowel Syndrome (gas, bloating, diarrhea and/or constipation)?

(50 pts) ☐ Do you have chronic sinusitis, nasal congestion, or post nasal drip?

(25 pts) ☐ Have you ever had prostatitis or vaginitis?

(15 pts) ☐ Have you taken birth control pills?

(15 pts) ☐ Have you taken corticosteroids such as Prednisone, Cortef, or Medrol

(20 pts) ☐ 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 pts) ☐ Do you crave: Sugar or Breads?

_____ TOTAL

PARASITES AND OTHER BOWEL INFECTIONS

Answer 33-36 only if you have diarrhea, gas or bloating

☐ 31. Did your problems begin with a diarrhea attack

☐ 32. Do you sometimes have severe diarrhea

☐ 33. Did loose stool symptoms begin in association with antibiotics?

☐ 34. Do you have well water?

SINUSITIS/NASAL CONGESTION

☐ 35. Do you have chronic nasal congestion or post nasal drip?

☐ 36. Do you have chronic yellow or green nasal discharge?

OTHER ANTIBIOTIC SENSITIVE INFECTIONS

- ☐ 37. Has any antibiotic improved your CFS/FMS symptoms?
- ☐ 38. Do you have chronic or intermittent low-grade fevers?
- ☐ 39. Do you get scabbing scalp sores?
- ☐ 40. Do you have chronic lung congestion?
- ☐ 41. Are you allergic to 2 or more unrelated antibiotics?
- ☐ 42. Do you have vertigo (feeling like you or the room are "spinning in a circle")?
- ☐ 43. Have you had a rash after a tick bite that looked like a “Bulls Eye"?

ESSENTIAL FATTY ACID DEFICIENCIES

- ☐ 44. Dry eyes?
- ☐ 45. Dry mouth?

ORTHOSTATIC INTOLERANCE/LOW BLOOD PRESSURE (NMH/POTS)

- ☐ 46. Dizziness or low blood pressure?
- ☐ 47. Did you ever have a positive Tilt Table Test?
- ☐ 48. Do you have CFS without widespread pain?

ANXIETY/HYPERVENTILATION

- ☐ 49. Panic attacks
- ☐ 50. Shortness of breath that comes and go suddenly (not with exercise) or sudden attacks of inability to take a deep enough breath?
- ☐ 51. Numbness or tingling around your lips or mouth?

DEPRESSION

- ☐ 52. Do you feel depressed (as opposed to frustrated over not being able to function)?
- ☐ 53. Do you have suicidal thoughts?

Please write about your experience with the illness. How it began, how it affects your life, what it feels like, significant factors, questions you have, and anything else your health practitioner may find helpful. Include a list of treatments you’ve tried, noting which ones helped and which did not help. (Use other side of this paper)