Lyme - Tick Borne Disease - Initial Symptom Check List

Name: ____ Date: _____________________

Risk Profile: (Please check all that apply)
Tick infested area ___ Frequent Outdoor Activities___ Hiking___ Fishing___ Camping ___ Gardening ___
Hunting ___ Ticks noted on pets ___
Do you remember being bitten by a tick? No ___ Yes___ When? _______
Do you remember having a "bulls eye rash"? No___ Yes___
Any other rash? No____ Yes____

Do you now have or have you recently had any of the following symptoms? Check all yes answers

1. _____Unexplained fevers, sweats, chills, or flushing
2. _____Unexplained weight change…..Loss or Gain
3. _____Fatigue, tiredness
4. _____Unexplained hair loss
5. _____Swollen glands
6. _____Sore throat
7. _____Testicular pain/ pelvic pain
8. _____Unexplained menstrual irregularity
9. _____Unexplained milk production; breast pain
10. _____Irritable bladder or bladder dysfunction
11. _____Sexual dysfunction or loss of libido
12. _____Upset stomach
13. _____Change in bowel function….Constipation or Diarrhea
14. _____Chest pain or rib soreness
15. _____Shortness of breath, cough
16. _____Heart palpitations, pulse skips, heart block
17. _____Any history of a heart murmur or valve prolapsed? Yes or No
18. _____Joint pain or swelling
    List Joints: ____
19. _____Stiffness of the joints, neck or back
20. _____Muscle pain or cramps
21. _____Twitching of the face or other muscles
22. _____Headaches
23. _____Neck cracks; neck stiffness
24. _____Tingling, numbness, burning or stabbing sensations
25. _____Facial paralysis (Bell's Palsy)
26. _____Eyes/Vision: double, blurry
27. _____Ears/Hearing: buzzing, ringing, ear pain
28. _____Increased motion sickness, vertigo
29. _____Lightheadedness, wooziness, poor balance, difficulty walking
30. _____Tremor
31. _____Confusion, difficulty thinking
32. _____Difficulty with concentration or reading
33. _____Forgetfulness, poor short term memory
34. _____Disorientation: getting lost, going to wrong places
35. _____Difficulty with speech or writing
36. _____Mood swings, irritability, depression
37. _____Disturbed sleep…too much or too little or early awakening
38. _____Exaggerated symptoms or worse hangover from alcohol

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MULTI-CHRONIC INFECTIOUS DISEASE SYNDROM
POTENTIAL PATIENT QUESTIONAIRE

Name: ____________________________________ Date: ____________ Age: ______

1. Where do you live? City:__________________________ State:_________________
2. How long have you been sick? (circle) <1 yr 1-2 yrs 3-5 yrs 6-10 yrs >10 yrs (__)
   a. Have you been continuously ill (______) or have had periods of recovery and relapse? (____) (check whichever applies)
   b. Rate your overall health status including level of pain, fatigue, neurologic or other symptoms by circling the number that applies:
      (severely ill) 1 2 3 4 5 6 7 8 9 10 (healthy)
3. What is your status (check one)
   a. ____ Working full time at an office
   b. ____ Working part time at an office
   c. ____ Working full time at home
   d. ____ Working part time at home
   e. ____ Not working due to health problems
   f. ____ Not working for other reasons
   g. ____ Have you been declared disabled and are receiving any disability services (insurance, financial support, etc.)
4. What infections have you been either diagnosed with or are suspected based on clinical symptoms? Check all that apply:
   a. _____ Borrelia (Lyme Disease)
   b. _____ Bartonella
   c. _____ Babesia - any specific species? _________________
   d. _____ Other bacteria? _______________________________
   e. _____ Mycoplasma
   f. _____ Viruses - any specific species? _________________
   g. _____ Parasites - any specific species? _________________
   h. _____ Fungi and Yeast (Candida and other species)
   i. _____ Other _______________________________________

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5. Have you ever been on any antibiotics? Check which applies:
   a. ____ Currently taking antibiotics for the first time (check one below)
      i. _____ Taking only oral antibiotics
      ii. _____ Taking IV and oral antibiotics
   b. ____ Have taken antibiotics in the past and am not on them now
   c. ____ Have taken antibiotics, stopped for a while, then resumed and am on them now
   d. What is the total time you have been on antibiotics? ____________
   e. Did you receive any IV antibiotics? Yes No
   f. If so, how long? _____________
   g. Did you feel you got any benefit from taking antibiotics? Circle the number that applies:
      (no benefit) 1 2 3 4 5 6 7 8 9 10 (great benefit)
6. Have you ever used any non-antibiotic therapies to treat your condition? Yes No
   a. If so, what have you used? (check all that apply)
      i. _____ Herbals
      ii. _____ Homeopathic
      iii. _____ Detoxification Therapies (colon therapy, chelation, glutathione, fasting)
      iv. _____ Hyperbaric Oxygen
      v. _____ High Dose IV Vitamin C
      vi. _____ Other:____
   b. Do you feel that any of these therapies were helping? Circle the number that applies:
   c. Did you feel you got any benefit from taking antibiotics? Circle the number that applies:
      (no benefit) 1 2 3 4 5 6 7 8 9 10 (great benefit)
7. Are you on any pain medications? Yes No
   a. If so, which ones?
      i. ______________________________
      ii. ______________________________
      iii. ______________________________
      iv. ______________________________
   b. How long have you been on pain medications? _____________
8. Have you ever had any lab tests that have shown any liver problems (elevated liver enzymes)
   Yes No
   a. If so, how long did this last? ____________
   b. Did it resolve? Yes No When if it has? ____________________

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9. Check any secondary problems that you are experiencing beyond the typical tick-borne infection symptoms:
   a. _____ Women's hormonal issues (PMS, cramping, exaggerated peri-menopausal sx)
   b. _____ Neuropathy (numbness and tingling in your extremities)
   c. _____ Digestive problems – indigestion, heartburn, gas, bloating, abnormal BM's, etc.
   d. _____ Changes in vision or hearing
   e. _____ Yeast overgrowth (rectal itching, carbo craving, nail fungus, jock itch, discharge)
10. Check whichever applies regarding dental amalgam fillings:
    a. _____ I have never had any amalgam fillings.
    b. _____ I currently have amalgam fillings. Number:_______
    c. _____ I used to have amalgam fillings and have had them replaced with non-toxic materials or crowns.
       i. If you have had your amalgams replaced, check the type of dentist who did it:
          1. _____ A Biological Dentist who uses protective equipment to prevent mercury from entering the body during the procedure.
             a. Did you find this dentist through the IAOMT (International Association of Oral Medicine and Toxicology) Yes No
          2. _____ My family dentist who did not use any protective equipment that I was aware of.
       ii. Did you experience any adverse effects from the removal of your amalgam fillings? (circle)Yes No
          1. If so, describe:____

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