

CHRONIC DISEASE QUESTIONNAIRE

NAME: _____ DATE: _____

SEX: _____ AGE: _____ MONTH/YEAR you first became ill: _____

IF RELAPSING, MONTH/YEAR most recent relapse: _____

HAS THERE BEEN A MARKED CHANGE IN ILLNESS PATTERN OR SEVERITY: (CIRCLE ONE) YES NO

Pattern Change: YES NO

Severity Change: YES NO

TOP THREE SYMPTOMS AT ONSET:

1. _____

2. _____

3. _____

TOP THREE SYMPTOMS AT PRESENT:

1. _____

2. _____

3. _____

LIST ANY SERIOUS COMPLICATIONS DUE TO THIS SYMDROME: _____

ARE YOU: (CIRCLE)

A. SICK ALL THE TIME

B. PARTIALLY RECOVERED

C. NOT RECOVERED

D. STEADILY WORSE

REVIEW OF MEDICAL SYSTEMS

CIRLCE THE LETTERS THAT **SIGNIFICANTLY** APPLY TO YOUR ILLNESS:

- A. Recurrent fever (or subnormal temperature)
- B. Scratchy throat several days per month
- C. Sleep disturbance, either insomnia or overtired
- D. Prolonged fatigue after minimal effort
- E. Abrupt onset of illness
- F. Swollen glands/tenderness in neck, armpit or groin

- G. New type of headaches
- H. Aches or pains in joints
- I. Muscle aches or pains
- J. Generalized muscle weakness
- K. Onset of illness occurred over a few days

NEUROPSYCHOLOGICAL COMPLAINTS SUCH AS:

- A. Eyes sensitive to bright light
- B. Blind spots in the vision
- C. Forgetfulness, memory problems
- D. Unable to hold a train of thought
- E. New trouble with math
- F. Occasionally do foolish or dangerous things, for no apparent reason

- G. Confusion or disorientation in familiar places
- H. Difficulty comprehending or concentrating
- I. Difficulty with or concern with driving
- J. Trouble speaking or use of words
- K. Irritability or emotional liability

NAME: _____

ACCESSORY COMPLAINTS AND SYMPTOMS:

- A. Night Sweats
- B. Stomach ache, heartburn, indigestion
- C. Chills / cold all the time
- D. Swallowing or esophageal problems
- E. Nausea or vomiting
- F. Frequent diarrhea or constipation
- G. Abdominal cramping
- H. Loss of appetite
- I. Pelvic pain unrelated to menstruation
- J. Weight loss or gain (specify)
- K. Cough
- L. Tingling or odd sensations (specify)
- M. Chest fullness or pain
- N. Paralysis or severe weakness of arm or leg
- O. New tremor or trembling
- P. Unusual jerking or muscle twitching
- Q. Dizziness or vertigo
- R. Depression or unusual mood changes
- S. Staggering gait
- T. Anxiety or feeling of panic
- U. Mouth, lip or tongue ulcers
- V. Continuous or recurrent respiratory problems
- W. Shingles or Herpes Zoster
- X. Allergies worse, new sensitivity to odors or chemicals
- Y. Rash
- Z. Visual Problems
- AA. Ringing in the ears
- BB. Dry eyes and/or dry mouth
- CC. Always thirsty, parched
- DD. Swelling or edema
- EE. Hair loss
- FF. Shortness of breath with minimal exertion

GENERAL REVIEW OF SYSTEMS:

- A. Tuberculosis (TB) or positive TB skin test
- B. Lung disease, wheeze, trouble breathing
- C. Heart trouble, chest pain, fluttering
- D. Heart murmur or extra sound in the heart
- E. High blood pressure
- F. Ulcers, hepatitis, jaundice or gallbladder disease
- G. Kidney disease, stones, infections or cystitis
- H. Discomfort in pelvis or genitals
- I. Prostate trouble or difficulty urinating
- J. Menstrual disorder or abnormal periods
- K. Premenstrual syndrome (PMS)
- L. Sexual concerns, lack of interest
- M. Blood disorders, anemia, blood in stool
- N. Sugar diabetes or thyroid disorder
- O. Arthritis, recurrent pain in neck or back
- P. Mental or emotional problems
- Q. Seizures or convulsions, even as a child
- R. Fainting or lightheadedness
- S. Significant problems with eyes, ears, nose or throat

PAST MEDICAL HISTORY

PLEASE LIST DATES AND REASONS FOR ANY HOSPITALIZATIONS: (USE SEPARATE SHEET IF NECESSARY)

HAVE YOU EVER BEEN HOSPITALIZED FOR MENTAL OR EMOTIONAL ILLNESS?

YES

NO

If yes, please explain: _____

HAVE YOU EVER BEEN IN COUNSELING WITH A PSYCHOLOGIST, PSYCHIATRIST OR OTHER COUNSELOR? **YES** **NO**

REASON(S) FOR COUNSELING: (CIRCLE)

- | | | | | | |
|-------------------------|------------|----------|---------|-------|--------|
| FAMILY ISSUES | DEPRESSION | MARITAL | SUICIDE | ABUSE | CAREER |
| ALCOHOL/SUBSTANCE ABUSE | | ACADEMIC | OTHER | | |

NAME: _____

PLEASE LIST CURRENT MEDICATIONS AND DOSE, INCLUDING VITAMINS, LAXATIVES, HORMONES, SLEEPING PILLS, INJECTIONS, TOPICALS AND DROPS: (USE SEPARATE SHEET IF NECESSARY)

LIST ANY DRUG ALLERGIES AND WHAT TYPE OF REACTION YOU HAD.

DRUG:

REACTION:

SINCE YOUR ILLNESS, HAVE YOU USED ANY OF THE FOLLOWING MEDICATIONS? (CIRCLE)

Prozac	Wellbutrin	Elavil-Amitriptyline	Sinequan-Doxepin	Valium
Tranxene	Xanax	Buspar	Ativan	Klonopin
Restoril	Dalmane	Steroid-Cortisone	Halcion	ProSom
Doral	Medrol	Prednisone	ACTH	Gammaglobulin
B-12/Cobalamin	Ampligen	Alpha interferon	Kutapressin	Magnesium injections
Pamelor-Nortriptyline		Tofranil-Imipramine	Desyrel-Trazodone	

DO YOU USE TOBACCO IN ANY FORM? **YES** **NO** HOW MANY PACKS DAILY? _____

INDICATE YOUR USE OF ALCOHOL:

_____ Infrequent (Holidays, special occasions)
_____ Occasional (1-2 drinks per month)
_____ Regular: _____ beers per week _____ wine per week _____ cocktails per week
_____ Drinking has been a problem or concern in the past

INDICATE YOUR USE OF CAFFEINE:

Coffee _____ cups daily tea _____ cups daily soft drinks (8 oz) _____ daily

ARE YOU ON ANY SPECIAL DIET? (Vegetarian, diabetic, low fat, low carbohydrate, no yeast, weight reduction)

YES **NO** Specify: _____

NAME: _____

FAMILY AND SOCIAL HISTORY

MARITAL STATUS (present, please circle) SINGLE MARRIED DIVORCED WIDOWED REMARRIED

NUMBER OF CHILDREN _____ HOW MANY BY FIRST MARRIAGE _____ BY CURRENT MARRIAGE _____

ARE YOUR CHILDREN GENERALLY HEALTHY? **YES** **NO**

WHAT IS YOUR OCCUPATION: _____

DO YOU WORK ROTATION OR SWING SHIFTS? **YES** **NO**

HOW MANY DAYS OF WORK OR SCHOOL HAVE YOU MISSED IN THE PAST SIX MONTHS? _____

WHEN, IF EVER, DID YOU STOP WORKING? _____

HAVE YOU BEEN ON SHORT-TERM DISABILITY? **YES** **NO**

IF YES, WHEN AND FOR WHAT REASON: _____

HAVE YOU BEEN ON LONG-TERM DISABILITY? **YES** **NO**

IF YES, WHEN AND FOR WHAT REASON: _____

WHAT IS YOUR EDUCATION? (HIGHEST GRADE OR DEGREE COMPLETED): _____

WHAT IS YOUR SPOUSE'S EDUCATION? _____

TELL US ABOUT YOUR FAMILY:

HOW OLD IS YOUR FATHER? _____ IF DECEASED, WHAT AGE DID HE DIE? _____

HOW OLD IS YOUR MOTHER? _____ IF DECEASED, WHAT AGE DID SHE DIE? _____

HOW MANY BROTHERS DO YOU HAVE? _____ HOW MANY SISTERS? _____

PLEASE ANSWER THE FOLLOWING QUESTIONS, CONSIDERING ONLY YOUR IMMEDIATE FAMILY: Include, mother (M), father (F), brothers (B), sisters (S), grandmothers (GM), grandfather (GF), aunts (A), uncles (U) and your children (Ch). Use abbreviations to indicate who, if anyone, in your family has had the following:

Cancer
Multiple Sclerosis
Muscular disorder

lymphoma or Leukemia
Emotional or mental illness
Nervous system disorder

Lupus (SLE)
Thyroid disease
Chronic Fatigue

EPIDEMIOLOGY

DID YOUR ILLNESS START AFTER ANY OF THE FOLLOWING: (CIRCLE TO INDICATE IF YES)

Infectious Illness

Immunization

A trip or vacation

Accident

Surgery or childbirth

Severe stress

Other, (please specify) _____

IF YES TO ANY, PLEASE EXPLAIN: _____

NAME: _____

DO YOU RECALL HAVING HAD "MONO" AS A CHILD, TEEN OR ADULT? **YES** **NO**

If yes, how ill were you? (CIRCLE) **SLIGHTLY** **MODERATELY** **SEVERELY**

How long were you ill? _____

HAD YOU VISITED AN UNDERDEVELOPED OR THIRD WORLD COUNTRIES BEFORE YOU BECAME ILL? _____

If yes, when and what country? _____

DO YOU KNOW ANYONE CLOSE TO YOU WHO HAS HAD A SIMILAR ILLNESS? **YES** **NO**

Who? _____

Were they ill BEFORE or AFTER you became ill? _____

DO YOU BELIEVE YOU MAY HAVE CONTRACTED THIS FROM ANOTHER PERSON, AND IF SO, WHOM? _____

HAVE YOU HAD A PET DIE WITHIN THE LAST TWO YEAR? **YES** **NO**

CIRCLE ONE WORD FROM **EACH SET** THAT BEST DESCRIBES YOUR ACTIVITY AND YOUR SEXUAL PARTNER'S ACTIVITY DURING THE FIVE YEARS BEFORE YOUR ILLNESS:

YOU:

- | | | |
|-----------------|----------------|----------|
| 1. Monogamous | Non-monogamous | Celibate |
| 2. Heterosexual | Gay | Lesbian |

PARTNER:

- | | | |
|-----------------|----------------|----------|
| 1. Monogamous | Non-monogamous | Celibate |
| 2. Heterosexual | Gay | Lesbian |

DO YOU CONSIDER YOURSELF AT RISK OFR AIDS-HIV? (Multiple partners, drug use, homosexual relations, exposed to blood or body fluids) **YES** **NO**

HAVE YOU EVER BEEN TESTED FOR AIDS-HIV? **YES** **NO**

HAVE YOU RECEIVED A BLOOD TRANSFUSION IN THE PAST **YES** **NO**

DO YOU HAVE ANY SIGNIFICANT EXPOSURES? (Blood products, human secretions, excess irradiation, solvents, chemicals, furniture oils, paints or varnish) **YES** **NO**

HAVE YOU BEEN SUSPECTED TO HAVING A TICK RELATED ILLNESS SUCH AS ROCKY MOUNTAIN SPOTTED FEVER OR LYME DISEASE? **YES** **NO**

Please briefly describe your illness: (You may use a separate sheet or the back of this sheet if needed)