HUNTER-HOPKINS CENTER, P.A.
Charlotte, North Carolina

GENERAL QUESTIONNAIRE

Adults with Chronic Fatigue Syndrome and/or Fibromyalgia

1. Date completed: _____

2.` Name:_____ Phone Number:_____

3. Address: _____Other Phone:_____

City _____State _____ Zip _____

Country (if other than USA) _____

4. Sex: M F 5. Birthdate _____ 6. Age _____

7. Month / Year you first became ill: _____ / _____

If relapsing, month/year of most recent severe relapse _____ / _____

8. Top three symptoms <u>at onset:</u>

a
b.
c.

Top three symptoms <u>at present:</u>

a
b.
c.

9. Any serious complications directly or indirectly linked to this syndrome? Yes / No

a
b.
c.

10 Are you (please check most appropriate):

a	sick but stable	[ ]
b.	getting slowly worse	[ ]
c.	improving steadily	[ ]
d.	partially recovered	[ ]

11. How knowledgeable do you consider yourself with respect to CFS and/or FM? (circle or underline one):

Expert Very knowledgeable Well read Read some Not knowledgeable

12. Name and address of your primary care physician:

Name:
Clinic:
Street:
City/State/Zip:
Area code / Telephone:

13. Were you referred to this office by this physician? Yes / No

14. Any other physician? Yes / No

Name:
Clinic:
Street:
City/State/Zip:
Area code / Telephone:

If you wish a copy of reports to be sent to any of these physicians, then circle the name and initial here: _____

REVIEW OF SYMPTOMS

15. Check the boxes on the right that significantly apply to your illness:

	Initial (6 mos)	Later	Now
Recurrent fever or chills			
Sore or scratchy throat several days per month			
Swollen or tender glands in the neck, armpit or groin			
Prolonged fatigue after minimal effort			
Muscle aches and pains			
Generalized muscle weakness			
New type of headaches			
Aching, pain, or stiffness in joints			
Sleep problems or unrefreshing sleep			
Abrupt onset of illness over minutes or hours			
Onset of illness occurred over a few days			
Lifelong symptoms			

16. Check the boxes on the right that significantly apply to the neuropsycholgical aspects of your illness:

	Initial (6 mos)	Later	Now
Eyes sensitive to bright lights (photophobia)			
Forget recent conversations and events			
Confusion or disorientation in familiar places			
Difficulty concentrating			
Difficulty comprehending or retaining information			
Have to focus on one thing at a time			
Slow to process			
Frequently lose your train of thought			
Trouble expressing thoughts			
Trouble recalling words and numbers			
Speak the wrong words or make up words			
Frequently get words or numbers in the wrong order			
Difficulty making decisions			
Poor hand to eye coordination (e.g. clumsy)			
New trouble with math			
Difficulty with or concern about driving			
Very irritable or impatient			
Mood swings or emotional lability			

REVIEW OF SYSTEMS

17. Check those boxes that apply to your illness:

HEENT	Before Illness	After Illness
History of head injury or loss of consciousness		
History of significant injury or trauma		
Blurred vision		
Visual problems (other than blurred)		
Ringing in ears, or tinnitus		
Frequent earache		
Loss of hearing		
TMJ or temperomandibular joint dysfunction		
Dry eyes		
Dry mouth		
Constant thirst		
Cankers, cold sores, or mouth ulcers		
Excessive tooth decay		
Gum or periodontal disease		
Hoarseness		
Sensitivity to light		
Sensitivity to sound		
ALLERGY / IMMUNOLOGY	Before Illness	After Illness
Recurrent sinus problems		
Stuffy nose or nasal drainage		
Frequent need to clear throat		
Allergies, hayfever, inhalant allergies		
Allergy shots		
Hives, whelps, or urticaria		
Eczema		
CARDIOVASCULAR	Before illness	After Illness
Chest pain or angina		
Fluttering, palpitations, or heart awareness		
Abnormal heart beat, or arrhythmia		
Heart murmur, or extra sound in the heart		
Mitral valve prolapse		
High blood pressure		
Low blood pressure		
Other heart disorder		
PULMONARY	Before illness	After illness
Chronic cough		
Wheeze or asthma		
Shortness of breath on minimal exertion		
Difficulty breathing or air hunger at rest		
Chest fullness		
Tuberculosis (TB) or positive TB skin test		
Other lung or pulmonary disorder		

GASTROINTESTINAL	Before illness	After Ilness
Nausea or queasiness		
Vomiting, recurrent		
Irritable bowel syndrome		
Frequent diarrhea		
Frequent constipation		
Bloating, intestinal gas, or distention		
Abdominal cramping		
History of colitis of inflammatory bowel disease		
Heartburn or indigestion		
History of gastritis or ulcers		
Hiatus hernia or esophageal reflux		
History of hepatitis or yellow jaundice		
History of gallbladder problems		
Black or bloody stools		
Stools with mucus, oil, foam, or undigested strands		
Difficulty swallowing or esophageal problems		
GENITOURINARY	Before illness	After illness
Aching or discomfort in the pelvis or genitals		
Bladder infections or cystitis		
Interstitial cystitis		
Kidney disease		
Kidney stones		
Frequent daytime or nighttime urination (specify)		
Discomfort on urination		
Urinary incontinence		
Genital sores or herpes		
Prostate trouble		
Lack of interest in sex		
HEMATOLOGICAL / ONCOLOGICAL	Before Illness	After Ilnness
History of anemia		
Abnormal blood count		
Blood disorder or free-bleeding		
Cancer, lymphoma, leukemia		
ENDOCRINOLOGICAL	Before Illness	After Illness
Sugar diabetes		
Thyroid disorder (specify)		
Subnormal temperatures		
Heat or cold intolerance		
Flushing (redness without heat or sweating)		
Hot flashes (menopausal symptoms)		
MUSCULOSKELETAL	Before Illness	After Illness
Rheumatoid or osteoarthritis		
Lupus or other collagen vascular disorder		
Chronic low back pain		
Herniated or ruptured disks in the back or neck		

NEUROMUSCULAR	Before Illness	After Illness
Tingling or odd sensations (specify)		
Weakness or paralysis of an arm or leg (specify)		
New tremor or trembling		
Dizziness, lightheadedness, or faintness		
Vertigo (room spinning around)		
Blackouts, fainting, or syncope		
Seizures or convulsions		
Muscle jerking or twitching		
Fingers or hands turn blue or white when exposed to the cold (Raynaud's phenomenon)		
Other neurological problem (specify)		
DERMATOLOGICAL	Before Illness	After Illness
New or worsening acne		
Shingles or zoster		
Chronic or recurrent rash		
GENERAL	Before Illness	After Illness
Fever (temperature > 100^0 F orally)		
Night sweats		
Chills or chilliness		
Hot or cold all the time (specifiy)		
Loss of appetite		
Craving certain foods (for example, sweets)		
Compulsive or ravenous eating		
Weight gain or loss (specify)		
Swelling or edema		
Silicone implants (breast or otherwise)		
History of (or suspected) Lyme Disease		
PSYCHOLOGICAL	Before illness	After illness
Anxiety or feelings of panic		
Restlessness or hyperactivity		
Blueness or depressed mood		
Depression		
Suicidal thoughts		
Anger or irritability		
History of eating disorder (anorexia, bulimia)		
Other mental or emotional problems (specify)		

TESTING

18. Have you had any of the following tests?

Lyme antibody..…… [ ] Yes [ ] No
HIV…….. [ ] Yes [ ] No
Immune status testing……..[ ] Yes [ ] No
Allergy testing (skin or blood)…..[ ] Yes [ ] No
Exercise testing…….[ ] Yes [ ] No
Tilt table testing…….[ ] Yes [ ] No
MRI of the brain…….[ ] Yes [ ] No

19. Have you had any biopsies of tissues? [ ] Yes [ ] No
Please list tissue type(s)

PAST MEDICAL HISTORY

20. Please list the year and reason for any hospitalizations (use back of page if needed)

Year _____ Reason_____
Year _____ Reason_____
Year _____ Reason_____
Year _____ Reason_____
Year _____ Reason_____
Year _____ Reason_____

21. Have you ever been hospitalized for mental or emotional illness? [ ] Yes [ ] No

Year _____ Reason_____
Year _____ Reason_____
Year _____ Reason_____

22. Have you ever been in counseling with a psychiatrist? [ ] Yes [ ] No
With a psychologist or other counselor? [ ] Yes [ ] No

Reason for counseling (circle choices):

Depression	Anxiety	Suicide	Family issues
Separation	Divorce	Career	Academic
Alcohol or substance abuse		Physical or emotional abuse	
Coping with chronic illness		Other	

23. Are you currently in counseling? [ ] Yes [ ] No
With whom?

Name:
Clinic:
Street:
City/State/Zip:
Area code / Telephone:

MEDICATIONS

24. Please list your current medications and dosages, including over-the-counter meds, vitamins, laxatives, hormones, injections, topicals, and drops:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

25. Since your illness, have you used the following medications? (circle or underline)

Prozac	Wellbutrin	Elavil (amitriptyline)
Zoloft (sertraline)	Paxil	Effexor
Celexa	Serzone	
Buspar	Pamelor (nortriptyline)	Tofranil (imipramine)
Desyrel (trazadone)	Valium	Tranxene
Xanax (alprazolam)	Sinequan (doxepin)	Ativan (lorazepam)
Klonopin	Restoril (temazepam)	Dalmane
Halcion	ProSom	Doral
Ambien	Sonata	
Cortisol / prednisone	ACTH	
Gamma globulin	B12 (cobalamin)	Tryptophan
Kutapressin	Magnesium injections	
DHEA	NADH	Growth hormone
Ritalin	Dexedrine	Adderall
Provigil	Cylert	Amphetamine
Tegretol (carbamazepine)	Depakote	Lamictal
Gabitril	Neurontin	
Symmetrel (amantidine)	Diamox (acetazolamide)	
Flexeril (cyclobenzaprine)	Zanaflex	Soma (carisoprodol)
Tenormin (atenolol)	Beta blocker	Florinef(fludrocortisone)
Bentyl (dicyclomine)	Levsin (hyoscamine)	

ALLERGIES AND SENSITIVITIES

26. Please list any drug allergies or adverse reactions:

Drug _____	Rxn _____
Drug _____	Rxn _____
Drug _____	Rxn _____
Drug _____	Rxn _____
Drug _____	Rxn _____
Drug _____	Rxn _____
Drug _____	Rxn _____

27. Do you have food allergies or sensitivities? [ ] Yes [ ] No
If yes, list types of foods: _____
_____

This was determined by [ ] personal experience [ ] blood tests [ ] skin tests [ ] other

28. Do you have a new intolerance of alcohol since your illness began? [ ] Yes [ ] No

29. Do you have sensitivities to chemicals, odors, fumes, smoke, perfume or other?
[ ] Yes [ ] No Specify: _____
_____

30. Do you use diet drinks with aspartame or Nutrasweet™? [ ] Yes [ ] No
How many drinks per week? _____/week

31. Do you use aspartame, Nutrasweet™ or Equal™ as a sweetener? [ ] Yes [ ] No
How many per day (_____/day) or per week (_____/week)?

HABITS

32. Do you use tobacco in any form? [ ] Yes [ ] No
How many packs of cigarettes do you smoke daily? _____
How many years have you smoked? _____

33. Indicate your use of alcohol:

_____ None
_____ Infrequent (holidays, special occasions only)
_____ Occasional (perhaps 1-2 per month)
_____ Regularly: _____beers/week, _____wines/week, _____cocktails/week
_____ Drinking has been a problem or concern in the past

34. Indicate your use of caffeine:

Coffee: _____ cups/day Tea: _____ /day Caffeine soft drinks: _____/day

35. Are you on any special diet? (vegetarian, diabetic, low fat, low carb, no yeast, weight reduction, etc) [ ] Yes [ ] No Specify: _____

FAMILY, SOCIAL AND WORK HISTORY

36. Marital status <u>at present</u>:

Married ___ Remarried ___ Single, never married ___ Separated or divorced ___
Widowed ___

37. How many <u>biological children</u> do you have? _____ Boys _____ Girls
Are your biological children healthy? [ ] Yes [ ] No

How many <u>adopted children</u> do you have? _____ Boys _____ Girls

38. Spouse's name: _____

39. Spouse's occupation: _____

40. Does your spouse have a chronic illness or problem? [ ] Yes [ ] No
If yes, describe: _____
_____

41: What is the health of your spouse? (circle one)
Excellent Very good Good Fair Poor

42. Have you ever been the victim of sustained verbal abuse? [ ] Yes [ ] No

43. Have you ever been the victim of sustained physical abuse? [ ] Yes [ ] No

44. Are you now the victim of sustained verbal or physical abuse? [ ] Yes [ ] No

45. As a child, did you have behavioral problems? [ ] Yes [ ] No
A learning disorder? [ ] Yes [ ] No

46. As a child, were you subject to a dysfunctional home life? [ ] Yes [ ] No

47. Are you now subject to a dysfunctional homelife? [ ] Yes [ ] No

48. Education (circle your highest level of schooling)

a. to grade level _____ (1-12)
b. high school diploma or equivalent
c. some college
d. college degree (B.S., B.A.)
e. some post-graduate education
Field: _____
f. graduate or professional degree
Degree: _____

49. Your occupation: _____

50.. If working, are you on a rotating schedule or work night shifts? [ ] Yes [ ] No

51. If working or schooling, how many days of work/school have you missed in the past six months? _____

52. When, if ever, did you stop working? _____

53. Have you been on short term disability? [ ] Yes [ ] No

When and for what reason?:

54. Have you been on long term disability? [ ] Yes [ ] No

When and for what reason?:

55. What is your functional status for work and play? (circle most appropriate letter)
    a. Fully functional – able to do any average task
    b. Mostly functional – able to perform most average tasks
    c. Mild to moderate impairment – job or play limited
    d. Moderate to severe impairment – difficult to do many jobs, could do flexible part-time work but reliability could be a problem
    e. Fully disabled – cannot perform well in any job, but able to care for most self care tasks most of the time
    f. Largely home bound or shut in, occasional attendant care needed, self care often a problem
    g. Largely bed bound, require attendant care

56. Family income (optional – you may omit):
    a. Below $15,000 per year
    b. $15,000-$35,000 per year
    c. $35,000-$60,000 per year
    d. $60,000-$100,000 per year
    e. $100, 000-$200,000 per year
    f. Above $200,000 per year
    g. Above $300,000 per year

FAMILY HISTORY

57. Tell us about your family:

    How old is your father (approx.) _____ or at what age did he die? _____
    Of what?
    How old is your mother (approx.) _____ or at what age did she die? _____
    Of what?
    How many siblings are there? _____ Brothers _____ Sisters

58. Please consider your <u>immediate</u> family, living or dead, in answering the following questions:

    Use these abbreviations next to the listed disease / disorder:

M	Mother	F	Father
B	Brother	S	Sister
BC	Biological child	SC	Stepchild
GM	Grandmother	GF	Grandfather
BA	Biological aunt	BU	Biological uncle
Sp	Spouse		

Familial diseases and disorders (continued)

Brain tumor
Lymphoma
Leukemia
Cancer (list type)

Lupus (SLE)
Rheumatoid arthritis

Severe allergies
Asthma

Multiple sclerosis
Nervous system disorder

Muscular dystrophy
Musculoskeletal disorder (other than FM)

Diabetes
Thyroid disease
Osteoporosis

Premature cardiovascular disease (heart attack before age 55)
Heart disease (heart failure,valve problems)
Emphysema
Lung disease

Emotional disorder
Bipolar depression
Schizophrenia
Drug abuse
Alcohol abuse
Other mental disorder

Chronic fatigue
Chronic Fatigue Syndrome
Fibromyalgia
Lyme Disease

Please circle the abbreviations of those who are no longer living.

EPIDEMIOLOGY

59. Ethnic background (please check dominate ethnicity / ethnicities)

[ ] Caucasian
  [ ] Northern European
  [ ] Mediterranean (i.e., Hispanic, Greek, Italian)
[ ] Black
[ ] Asian
[ ] Native American
[ ] Jewish
[ ] Other _____

60. Did your illness start after: (circle)

a. an infectious illness
b. an accident
c. a trip
d. an immunization
e. surgery or delivery
f. severe stress
g. other _____

Can you be more specific about this?

61. Do you know anyone close to you who has a similar illness? [ ] Yes [ ] No
(Circle) Family Friend Lover Colleague Acquaintance

Were they ill before or after your illness?

62. Do you believe you may have contracted this from some other person? [ ] Yes [ ] No
If so, how?
What was your relationship?

63. Had you visited any under-developed or third world countries before you became ill?
[ ] Yes [ ] No

Year _____ Where? _____
Year _____ Where? _____
Year _____ Where? _____
Year _____ Where? _____
Year _____ Where? _____

64. Circle <u>one word</u> from <u>each set</u> that best characterizes your activity during the 5 years <u>before</u> your illness (optional – you may omit all or part):

Set 1 - Monogamous/near monogamous, non-manogamous, celibate
Set 2 - Heterosexual, gay, lesbian, bisexual

65. Circle <u>one word</u> from <u>each set</u> that best characterizes your sexual partner's activity during the 5 years <u>before</u> your illness (optional – you may omit all or part):

Set 1 - Monogamous/near monogamous, non-monogamous, celibate
Set 2 - Heterosexual, gay, lesbian, bisexual

66. Do you consider yourself at possible risk for AIDS or HIV? (High risk sex, drug user, homosexual, exposed to blood or body fluids) [ ] Yes [ ] No

67. Have you ever received a blood transfusion? [ ] Yes [ ] No
Year _____ City _____
Year _____ City _____
Year _____ City _____

68. Have you sustained a contaminated needle stick? [ ] Yes [ ] No
Year of needle stick(s) _____

69. Have you ever been suspected of a tick-related illness such as Lyme Disease or Rocky Mountain Spotted Fever? [ ] Yes [ ] No

PLEASE BRIEFLY DESCRIBE THE HISTORY OF YOUR ILLNESS.
(You may use the back of this page or an additional page if needed)

Revised 9-25-01

Hunter-Hopkins Center

Charlotte, North Carolina

Modified Disability Scale

Name_____ **Date**_____

Please place a checkmark (✓) on the following scale that closest describes your activity level during the past month.

_____ 100: No symptoms at rest; No symptoms with exercise: Normal overall activity level; Able to work full time without difficulty.

_____ 90: No symptoms at rest; Mild symptoms with activity; Normal overall activity level; Able to work full time without difficulty.

_____ 80: Mild symptoms at rest symptoms worsened by exertion', minimal activity restriction noted for activities requiring exertion only; able to work full time with difficulty in jobs requiring exertion.

_____ 70: Mild symptoms at rest; some daily activity limitation clearly noted. Overall functioning close to 90% of expected except for activities requiring exertion; able to work full time with difficulty.

_____ 60: Mild to moderate symptoms at rest; daily activity limitation clearly noted. Overall functioning 70% to 90% Unable to work full time in jobs requiring physical labor, but able to work full time In light activity if hours flexible.

_____ 50: Moderate symptoms at rest. Moderate to severe symptoms with exercise or activity; overall activity level reduced to 70% of expected. Unable to perform strenuous duties, but able lo perform light duty or desk work 4-5 hours a day, but requires rest periods.

_____ 40: Moderate symptoms at rest Moderate to severe symptoms with exercise or activity overall activity level reduced to 50%-70% of expected. Not confined to house. Unable to perform strenuous duties: able to perform light duty or desk work 3-4 hours a day, but requires rest periods.

_____ 30: Moderate to severe symptoms at rest. Severe symptoms with any exercise; overall activity level reduced to 50% of expected. Usually confined to house. Unable to perform any strenuous tasks. Able to perform desk work 2-3 hours a day, but requires rest periods.

_____ 20: Moderate to severe symptoms at rest. Unable to perform strenuous activity; Overall activity 30%-50% of expected. Unable to leave house except rarely; Confined to bed most of day, Unable to concentrate for more than 1 hour a day.

_____ 10: Severe symptoms at rest Bed ridden the majority of the time. No travel outside of the house. Marked cognitive symptoms preventing concentration.

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Subjective Functional Capacity

Name_____ **Date**_____

Please circle the one best response for each activity described below:

Activities of Daily Living (bathing, dressing, feeding self. toilet)

4.Need some assistance
3.Slight difficulty
2.Minimal difficulty
1.No problem

Laundry

4.Unable
3.Occasionally
2.Regularly in small steps or with help
1.Regularly without help

Cooking

4.Unable
3.Take-out, breakfast, or simple lunch only
2.Simple microwave or crockpot meal
1.Regular meals

Housekeeping

4.Unable
3.Light dusting, straighten up
2.Regular housekeeping in small steps or with help
1.Regular

Grocery Shopping

4.Unable
3.Occasional (once or twice per month)
2.Frequent, but with assistance
1. No problem

Social Activities (church, temple, family and friends)

4.Unable
3.1nfrequently
2.0ccasionally (say once or twice per month)
1.Frequently (say weekly)

Driving

4.Unable
3.Very limited
2.Cautious. local trips
1.Distant trips or traffic

Errands or Light Chores (example, post office or drop off child)

4.None
3.0-1 per day
2.1-2 per day
1 .No or few restrictions

Score _____

Please indicate for how long you can perform the following activities on a typical day:

	Not At All	**15 minutes**	**30 minutes**	**60 minutes**	**1-3 hours**	**> 3 hours**
SEDENTARY (sitting, watching TV)	6	5	4	3	2	1
LIGHT ACTIVITY (eating, small crafts)	6	5	4	3	2	1
MODERATE ACTIVITY (tidy room, fix meal)	6	5	4	3	2	1
HEAVY ACTIVITY (vacuum room, rake)	6	5	4	3	2	1

Score from Side 1 _____

Score from Side 2 _____

TOTAL SCORE _____

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Fatigue Scale

Name_____ **Date**_____

These questions are about fatigue and the effect of fatigue on your activities. For each of the following questions, circle the number that most closely indicates how you have been feeling during the **PAST WEEK.**

1. To what degree have you experienced fatigue (circle one)

   Not at all — A great deal

   1 2 3 4 5 6 7 8 9 10

   If you answered 'Not at all'. please stop here.

2. How severe is the fatigue which you have been experiencing? (circle one)

   Not at all — A great deal

   1 2 3 4 5 6 7 8 9 10

3. To what degree has the fatigue caused you distress? (circle one)

   Not at all — A great deal

   1 2 3 4 5 6 7 8 9 10

4. Over the PAST WEEK how often have you been fatigued? (check one)
   - [ ] Everyday (10)
   - [ ] Most, but not all days (8)
   - [ ] Occasionally, but not most days (6)
   - [ ] Hardly any days (4)
   - [ ] No days (2)

5. To what degree has your fatigue changed during the PAST WEEK? (check one)
   - [ ] Increased (10)
   - [ ] Fatigue has gone up and down (8)
   - [ ] Stayed the same (6)
   - [ ] Decreased (4)
   - [ ] I didn't have any fatigue this past week (2)

Now circle the number that most closely indicates to what degree fatigue has interfered with your ability to do the following activities in the **PAST WEEK**. For activities you don't do, for reasons other than fatigue (for example, you don't work because you are retired), check the box at the left.

Don't do activity	Not at all									A great deal
[ ] Household chores	1	2	3	4	5	6	7	8	9	10
[ ] Cook	1	2	3	4	5	6	7	8	9	10
[ ] Bathe or wash	1	2	3	4	5	6	7	8	9	10
[ ] Dress	1	2	3	4	5	6	7	8	9	10
[ ] Work	1	2	3	4	5	6	7	8	9	10
[ ] Visit or socialize	1	2	3	4	5	6	7	8	9	10
[ ] Sexual activity	1	2	3	4	5	6	7	8	9	10
[ ] Leisure/recreational activity	1	2	3	4	5	6	7	8	9	10
[ ] Shop and do errands	1	2	3	4	5	6	7	8	9	10
[ ] Walk	1	2	3	4	5	6	7	8	9	10
[ ] Exercise, other then walking	1	2	3	4	5	6	7	8	9	10

Score_____

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Charlotte, North Carolina

Fatigue Impact Scale*

Name_____ **Date**_____

Please rate how much of a problem fatigue has caused you during the past *month.* Mark the appropriate response for each question:

0=no problem 1=small problem 2=big problem 3=extreme problem.

Because of my fatigue:	**Response** (0=none, 3=extreme)	**Do Not Use**		
		C	**P**	**S**
I feel less alert				
I feel that I am more isolated from social contact				
I have to reduce my workload or responsibilities				
I am more moody				
I have difficulty paying attention for a long period				
I feel that I cannot think clearly				
I work less effectively (inside our outside the home)				
I have to rely more on others to help me do things for me				
I have difficulty planning activities ahead of time				
I am more clumsy and uncoordinated				
I find that I am more forgetful				
I am more irritable and more easily angered				
I have to be careful about pacing my physical activities				
I am less motivated to do anything that requires physical effort				
I am less motivated to engage in social activities				
My ability to travel outside my home is limited				
I have trouble maintaining physical effort for long periods				
I find it difficult to make decision				
I have few social contacts outside my own home				
Normal day to day events are stressful for me				
I am less motivated to do anything that requires thinking				
I avoid situations that are stressful for me				
My muscles feel weaker than they should				
My physical discomfort is increased				
I have difficulty dealing with anything new				
I am less able to finish tasks that require thinking				
I feel unable to meet the demands that people put on me				
I am less able to provide financial support for me and my family				
I engage in less sexual activity				
I find it difficult to organize my thoughts when I am doing things				
I am less able to complete tasks that require physical effort				
I worry about how I look to other people				
I am less able to deal with emotional issues				
I feel slowed down in my thinking				
I find it hard to concentrate				
I have difficulty participating fully in family activities				
I have to limit my physical activities				
I require more frequent or longer periods of rest				
I am not able to provide as much emotional support to my family as I should				
Minor difficulties seem like major difficulties				
Summation				

*** Based on Fisk JD et al., Measuring the functional impact of fatigue: initial validation of the fatigue impact scale, Clin Infect Dis (1994 Jan); 18 Suppl I:S79-S83**

Hunter-Hopkins Center

Charlotte, North Carolina

HDAS

Name_____ **Date**_____

Doctors are aware that emotions play an important part in most illnesses. If your doctor knows about these feelings, he or she will be better able to help you.

This questionnaire is designed to help your doctor know how you feel. Read each item and ***underline*** the reply that comes closest to how you have been feeling in the past week.

Don't take too long over your replies; your immediate reaction to each item will probably be more accurate than a long, thought-out response.

A I feel tense or 'wound up':
3 _ Most of the time
2 _ A lot of the time
1 _ From time to time, occasionally
0 _ Not at all

D I still enjoy the things I used to enjoy:
0 _ Definitely as much
1 _ Not quite so much
2 _ Only a little
3 _ Hardly at all

A I get a sort of frightened feeling as if something awful is about to happen:
3 _ Very definitely and quite badly
2 _ Yes, but not too badly
1 _ A little, but it doesn't worry me
0 _ Not at all

D I can laugh and see the funny side of things:
0 _ As much as I always could
1 _ Not quite so much now
2 _ Definitely not so much now
3 _ Not at all

A Worrying thoughts go through my mind:
3 _ A great deal of the time
2 _ A lot of the time
1 _ From time to time but not too often
0 _ Only occasionally

D I feel cheerful
0 _ Not at all
1 _ Not often
2 _ Sometimes
3 _ Most of the time

Hunter-Hopkins Center

Charlotte, North Carolina

Pain Assessment Survey

Name_____ **Date**_____

1. List your principle pain area(s) by choosing from the following list:

A. Headache	B. Muscle	C. Joint	D. Skin
E. Back	F. Bone	G. Pelvic	H. Abdomen
I. Chest	J. Other (Name)		

Worst Pain Area: _____
Next Worst:_____
Next Worst:_____
Next Worst:_____

If headache is one of your principle pain areas, rank the type of headache from the list below:

A. Pressure-like	B. Sharp pain	C. Muscle-tension
D. Other (name)	E. Uncertain	

Worst Headache:_____
Next Worst:_____
Next Worst:_____

2. Circle the amount of time you are <u>pain free:</u>

A. Almost all the time	(>9 5% of the time)
B. Most of the time	(>75% of the time)
C. Some of the time	(25-15% of the time) Give %_____
D. Hardly ever	(<25% of the time)
E. Almost never	(<5% of the time)

3. When in pain, what is the <u>most severe</u> pain like? (Mark on the scale below)

No Pain ├──┤ **Worse Pain**

4. When in pain, what is the typical or average pain like?
(Mark on the scale below)

No Pain ├──┤ **Worse Pain**

5. Circle the face that best represents the amount of pain felt when in pain.

0 1 2 3 4 5 6

6. How often do you use pain medications? (Circle your choice below)

A. Infrequent (Not daily)
B. Frequent (Daily)
C. Very frequent (More than twice daily)
D. Constantly (Four or more times daily)

7. List the pain medicine(s) you typically use:

_____ _____
_____ _____
_____ _____

8. When you use pain -medicines, how helpful are they? (Circle your choice below)

A. Leave me pain free
B. Help a lot
C. Help modestly
D. Help a little
E. Do not help

9. Do certain situations (stress, constipation, PMS) or things (foods, chemicals, or irritants) <u>reliably</u> trigger your pain?

A. Yes B. No C. Sometimes

Hunter-Hopkins Center

Charlotte, North Carolina

Multiple Symptom Questionnaire (MSQ)*

Name_____ **Date**_____

Rate each of the following symptoms based upon your health profile for the past 30 days.

POINT SCALE:
0 = Never or almost never have the symptom
1 = Occasionally have it, effect is not severe
2 = Occasionally have It, effect Is severe
3 = Frequently have it, effect is not severe
4 = Frequently have it, effect is severe

DIGESTIVE TRACT

_____Nausea or vomiting
_____Diarrhea
_____Constipation
_____Bloated feeling
_____Belching, or passing gas
_____Heartburn

_____**Total**

EARS

_____Itchy ears
_____Earaches, ear Infections
_____Drainage from ear
_____Ringing in ears, hearing loss

_____**Total**

EMOTIONS

_____Mood swings
_____Anxiety, fear or nervousness
_____Anger, irritability, or Aggressiveness
_____Depression

_____**Total**

ENERGY / ACTIVITY

_____Fatigue, sluggishness
_____Apathy, lethargy
_____Hyperactivity
_____Restlessness

_____**Total**

**Based on the Cornell MSQ*

EYES

_____Watery or itchy eyes
_____Swollen, reddened or sticky eyelids
_____Bags or dark circles under eyes
_____Blurred or tunnel vision
(does not Include near- or far-sightedness)

_____**Total**

HEAD

_____Headaches
_____Faintness
_____Dizziness
_____Insomnia

_____**Total**

HEART

_____Irregular or skipped heartbeat
_____Rapid or pounding heartbeat
_____Chest Pain

_____**Total**

JOINTS / MUSCLES

_____Pain or aches In Joints
_____Arthritis
_____Stiffness or limitation of movement
_____Pain or aches In muscles
_____Feeling of weakness or tiredness

_____**Total**

LUNGS

_____Chest congestion
_____Asthma, bronchitis
_____Shortness of breath
_____Difficulty breathing

_____**Total**

MIND

_____Poor memory
_____Confusion, poor comprehension
_____Poor concentration
_____Poor physical coordination
_____Difficulty In making decisions
_____Stuttering or stammering
_____Slurred speech
_____Learning disabilities

_____**Total**

MOUTH / THROAT

_____Chronic coughing
_____Gagging, frequent need to clear throat
_____Sore throat, hoarseness, loss of voice
_____Swollen or discolored tongue, Sums, lips
_____Canker sores

_____**Total**

NOSE

_____Stuffy nose
_____Sinus problems
_____Hay fever
_____Sneezing attacks
_____Excessive mucus formation

_____**Total**

SKIN

_____Acne
_____Hives, rashes, or dry skin
_____Hair loss
_____Flushing or hot flashes
_____Excessive sweating

_____**Total**

WEIGHT

_____Binge eating/drinking
_____Craving certain foods
_____Excessive weight
_____Compulsive eating
_____Water retention
_____Underweight

_____**Total**

OTHER

_____Frequent illness
_____Frequent or urgent urination
_____Genital Itch or discharge

_____**Total**

_____***GRAND TOTAL***

COMMENTS:

Health Status Questionnaire 2.0

Modified from the Microtest Q™ Assessment System

Name: _____

Birth Date: _____ Test Date: _____

Gender: [1] Male [2] Female

Race: [1] Black [2] White [3] Oriental [4] Native American [5] Hispanic [6] Other

Family Income (What was your family's total income last year before taxes?):

[1] Less than $10,000
[2] $10,000 – 19,999
[3] $20,000 – 29,999
[4] $30,000 – 39,999
[5] $40,000 – 49,999
[6] $50,000 – 59,999
[7] $60,000 – 69,999
[8] $70,000 – 79,999
[9] $80,000 or more

Highest Educational Level:

[1] 8th grade or less
[2] Some high school
[3] High school graduate
[4] Some college
[5] College graduate
[6] Any post-graduate work

Marital Status:

[1] Never married
[2] Married
[3] Separated
[4] Divorced
[5] Widowed

INSTRUCTIONS:

This survey asks for your views about your health, and will help us to track how you feel and how well you are able to do your usual activities.

Answer every question by marking the best answer. If you are unsure, please give the best answer you can.

1. **In general**, would you say your health is:

① Excellent

② Very Good

③ Good

④ Fair

⑤ Poor

2. **Compared to one year ago**, how would you rate your health in general **now**?
   - ① Much better than one year ago
   - ② Somewhat better than one year ago
   - ③ About the same
   - ④ Somewhat worse now than one year ago
   - ⑤ Much worse now than one year ago

The following items are about activities you might do during a typical day. Does **your health now limit you** in these activities? If so, how much?

Ques	Yes Limited a Lot	Yes Limited a little	No Not limited	
3	①	②	③	**Vigorous activities**, such as running, lifting heavy objects, strenuous sports
4	①	②	③	**Moderate activities**, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf
5	①	②	③	Lifting or carrying groceries
6	①	②	③	Climbing **several** flights of stairs
7	①	②	③	Climbing **one** flight of stairs
8	①	②	③	Bending, kneeling, or stooping
9	①	②	③	Walking **more than a mile**
10	①	②	③	Walking **several blocks**
11	①	②	③	Walking **one block**
12	①	②	③	Bathing or dressing yourself

During the **past 4 weeks** have you had any of the following problems with your work or other regular activities **as a result of your physical health**?

	Yes	No	
13	①	②	Cut down on the amount of time you spent on work or other activities
14	①	②	Accomplished less than you would like
15	①	②	We limited in the kind of work or other activities
16	①	②	Had difficulty performing work or other activities (for example, it took extra effort)

During the **past 4 weeks** have you had any of the following problems with your work or other regular daily activities **as a result of emotional problems** (such as feeling depressed or anxious)?

	Yes	No	
17	①	②	Cut down on the **amount of time** you spent on work or other activities
18	①	②	**Accomplished less** than you would like
19	①	②	Didn't do work or other activities as **carefully** as usual

20. During the **past 4 weeks**, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

① Not at all
② Slightly
③ Moderately
④ Quite a bit
⑤ Extremely

21. How much **bodily** pain have you had during the **past 4 weeks**?

① None
② Very mild
③ Mild
④ Moderate
⑤ Severe
⑥ Very severe

22. During the **past 4 weeks** how much did **pain** interfere with your normal work (including both work outside the home and housework)?

① Not at all
② A little bit
③ Moderately
④ Quite a bit
⑤ Extremely

These questions are about how you feel and how things have been with you during the past 4 weeks, For each question please give the one anser that comes closest to the way you have been feeling.

How much time during the **past 4 weeks** …

	All of the time	Most of the time	A good bit of the time	Some of the time	A little bit of the time	None of the time	
23	①	②	③	④	⑤	⑥	Did you feel full of pep?
24	①	②	③	④	⑤	⑥	Have you been a very nervous person?
25	①	②	③	④	⑤	⑥	Have you felt so down in the dumps that nothing could cheer you up?
26	①	②	③	④	⑤	⑥	Have you felt calm and peaceful?
27	①	②	③	④	⑤	⑥	Did you have a lot of energy?
28	①	②	③	④	⑤	⑥	Have you felt downhearted and blue?
29	①	②	③	④	⑤	⑥	Did you feel worn out?
30	①	②	③	④	⑤	⑥	Have you been a happy person?
31	①	②	③	④	⑤	⑥	Did you feel tired?

32. During the **past 4 weeks** how much of the time has your **physical health or emotional problems** interfered with your social activities (like visiting with friends, relaties, etc.)?

① All of the time

② Most of the time

③ Some of the time

④ A little of the time

⑤ None of the time

How TRUE or FALSE is <u>each</u> of the following statements for you?

	Definitely true	Mostly true	Don't know	Mostly false	Definitely false	
33	①	②	③	④	⑤	I seem to get sick a little easier than other people
34	①	②	③	④	⑤	I am as healthy as anybody I know
35	①	②	③	④	⑤	I expect my health to get worse
36	①	②	③	④	⑤	My health is excellent

Please answer YES or NO to each of the following questions.

	Yes	No	
37	①	②	In the past year have you had 2 weeks or more during which you felt sad, blue, or depressed; or when you lost all interest or pleasure in things that you usually cared about or enjoyed?
38	①	②	Have you had 2 years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes?
39	①	②	Have you felt depressed or sad much of the time in the past year?

Microtest Q Assessment System™

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