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

GENERAL QUESTIONNAIRE

Children and Adolescents with Chronic Fatigue Syndrome and/or Fibromyalgia

1. Date completed: _____ By whom? _____
2.` Name:_____ Phone Number:_____
3. Address: _____Other Phone:_____

   City _____State _____ Zip _____

   Country (if other than USA) _____
4. Sex: M F 5. Birthdate _____ 6. Age _____
5. Month / Year you first became ill: _____ / _____

   If relapsing, month/year of most recent severe relapse _____ / _____
6. Top three symptoms at onset:

   a
   b.
   c.
7. Top three symptoms at present:

   a
   b.
   c.
8. Any serious complications directly or indirectly linked to this syndrome? Yes / No

   a
   b.
   c.
9. Are you (please check most appropriate):

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

10. Name and address of your primary care physician:

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

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

12. 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

13. 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			

14. 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

15. 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		
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 (specify)		
Loss of appetite		
Craving certain foods (for example, sweets)		
Compulsive or ravenous eating		
Weight gain or loss (specify)		
Swelling or edema		
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

16. 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

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

PAST MEDICAL HISTORY

18. 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_____

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

Year _____ Reason_____
Year _____ Reason_____
Year _____ Reason_____

20. 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
Career Academic Alcohol or substance abuse
Physical or emotional abuse Coping with chronic illness
Other

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

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

MEDICATIONS

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

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

23. 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

24. Please list any drug allergies or adverse reactions:

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

25. 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

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

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

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

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

HABITS

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

31. 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

32. Indicate your use of caffeine:

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

33. 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

34. Marital status: Married ___ Remarried ___ Single, never married

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

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

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

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

39. Are you now subject to a dysfunctional home life? [ ] Yes [ ] No

40. Education (circle your highest level of schooling)

    a. to grade level _____ (1-12)
    b. high school diploma or equivalent
    c. some college

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

42. When, if ever, did you stop working / schooling? _____

43. 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

43. 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

44. 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

45. Please consider your immediate 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

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

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

47. 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?

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

Were they ill before or after your illness?

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

50. 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? _____

51. 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

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

53. Have you sustained a <u>contaminated</u> needle stick? [ ] Yes [ ] No
Year of needle stick(s) _____

54. 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)

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

A I can sit at ease and feel relaxed:
0 _ Definitely
1 _ Usually
2 _ Not often
3 _ Not at all

D I feel as if I am slowed down:
3 _ Nearly all the time
2 _ Very often
1 _ Sometimes
0 _ Not at all

A I get a sort of frightened feeling like 'butterflies' in the stomach:
0 _ Not at all
1 _ Occasionally
2 _ Quite often
3 _ Very often

D I have lost interest in my appearance
3 _ Definitely
2 _ I don't take so much care as I should
1 _ I may not take quite as much care
0 _ I take just as much care as ever

A I feel restless as if I have to be on the move:
3 _ Very often indeed
2 _ Quite a lot
1 _ Not very much
0 _ Not at all

D I look forward with enjoyment to things:
0 _ As much as ever I did
1 _ Rather less than I used to
2 _ Definitely less than I used to
3 _ Hardly at all

A I get sudden feelings of panic:
3 _ Very often indeed
2 _ Quite often
1 _ Not very often
0 _ Not at all

D I can enjoy a good book or radio or TV program:
0 _ Often
1 _ Sometimes
2 _ Not often
3 _ Very seldom

Now check that you have answered all questions.

FOR CLINIC USE ONLY

D (8-10) _____ A (8-10) _____

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: