

Today's Date _____

Circulatory Dysfunction in the Chronic Fatigue

Screening Form

Write in the answer or circle yes or no. (This information will remain confidential.)

Name: _____

Birth Date: _____ Age: _____ Gender: M F

Height: _____ Weight: _____

Address: _____

City/State/Zip Code: _____

Telephone: (H) _____ (W) _____

Primary Physician's Name: _____

Primary Physician's telephone Number: _____

1. Do you have fatigue that has been present for at least 6 months? Yes No
2. If yes, has this fatigue:
 - a) resulted in a substantial reduction in your previous level of activity? Yes No
 - b) been the result of exertion? Yes No
 - c) improved with rest? Yes No
3. When did this fatigue begin? (Date): _____
4. Have you had similar fatigue off and on over your lifetime? Yes No
5. Have you been examined by a doctor to look for the cause of your fatigue?
 - a) was a medical history taken? Yes No
 - b) was a physical examination performed? Yes No
 - c) were blood tests done? Yes No

HEALTH HISTORY:

1. Please check all of the following symptoms that you have experienced either continuously or at least twice during any 6-month period since your chronic fatigue began. Do **NOT** check if you had this symptom **before** your chronic fatigue began.

- difficulty with concentration or short-term memory severe enough to cause a substantial reduction in previous levels of activity.
- sore throat
- tender lymph nodes (glands) in your neck or underarm. (muscle pain)
- pain in two or more joints without swelling or redness
- headaches of a new type, pattern or severity
- not feeling refreshed after sleep
- increased fatigue and not feeling well for more than 24 hours following physical exercise

2. Have you ever had a psychiatric evaluation? Yes No

3. Has a psychiatrist or other health professional ever said that you have (check if yes):

- depression
- bipolar disorder (manic depressive disorder)
- schizophrenia
- anorexia nervosa
- bulimia
- panic attacks
- anxiety disorder
- other diagnosis _____

4. Have you ever taken medication for depression or any other psychiatric disorder? Yes No
If yes, please list:

<u>Medication</u>	<u>Dose</u>	<u>Dates taken</u>	<u>Beneficial?</u>
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5. Describe your overall health history. List all significant medical problems and surgical operations you have had.

6. Do you have or have you ever had? (Check if yes.):

- | | |
|--|---|
| <input type="checkbox"/> hypothyroidism | <input type="checkbox"/> asthma |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> heart disease | <input type="checkbox"/> liver disease |
| <input type="checkbox"/> kidney disease | <input type="checkbox"/> bone disease |
| <input type="checkbox"/> glaucoma | <input type="checkbox"/> edema (swollen ankles) |
| <input type="checkbox"/> sleep apnea or narcolepsy | <input type="checkbox"/> alcohol or substance abuse |

ONSET OF CHRONIC FATIGUE (Write on a separate sheet if extra space is needed.):

1. Please describe your situation just before your chronic fatigue began. Were you in school or employed? What was your family situation? Had any major changes occurred recently? How was your physical, emotional and mental health? :

2. Circle any of the following symptoms that occurred during the first days of your illness: fever, sore throat, sore lymph glands, headache, cough, congestion, body aches, joint aches, abdominal pain, diarrhea.

At the time of the onset of your illness, did your doctor think you had an infection or any other illness, eg. the flu or mononucleosis?

- Yes, initially my doctor thought I had an infection: _____
- Yes, initially my doctor thought I had another illness: _____
- No, either I didn't see a doctor, or no illness was diagnosed.

3. Describe the onset of your chronic fatigue. List the first symptoms which developed and state if they occurred abruptly or slowly.

OTHER RELATED QUESTIONS:

1. What medications (prescription and non prescription, including aspirin, vitamins, herbs, nutritional supplements and laxatives) are you taking currently and how often?

<u>Medication</u>	<u>Dose</u>	<u>Frequency taken</u>	<u>Beneficial?</u>
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2. Are there any medications you would be unable to stop taking? _____ If so, please list:

3. On a scale of 0-100, with 0 being "dying" and 100 being "the best you can imagine a person to feel," how would you rate yourself today? _____

4. How much beer, wine, or other alcoholic beverage do you drink a day? _____
How much coffee do you drink a day? _____
Do you smoke cigarettes? Yes No How many per day? _____

5. Can you walk without assistance? Yes No

6. Can you reliably fill out and return questionnaires which take approximately 30 minutes to complete? Yes No

For females only:

Are you currently pregnant or nursing a baby? Yes No

Are you sexually active? Yes No

If yes:

What method of contraception are you using? _____

If you are able to get pregnant, are you willing to practice an effective method of birth control for the duration of the study? Yes No

What method? _____

FATIGUE SEVERITY SCALE

Circle the number from 1 - 7, for each question, that indicates how much you agree or disagree

with each statement.

	Strongly Disagree						Strongly Agree
1. My motivation is lower when I am fatigued.	1	2	3	4	5	6	7
2. Exercise brings on my fatigue.	1	2	3	4	5	6	7
3. I am easily fatigued.	1	2	3	4	5	6	7
4. Fatigue interferes with my physical functioning.	1	2	3	4	5	6	7
5. Fatigue causes frequent problems for me.	1	2	3	4	5	6	7
6. My fatigue prevents sustained physical functioning.	1	2	3	4	5	6	7
7. Fatigue interferes with carrying out certain duties	1	2	3	4	5	6	7
and responsibilities.							
8. Fatigue is among my three most disabling symptoms.	1	2	3	4	5	6	7
9. Fatigue interferes with my work, family, or social life.	1	2	3	4	5	6	7