

Lyme Disease Questionnaire

Name: _____ Date: _____

As part of your current illness have you had any of the following?
Please complete this form and bring it to your Physician.

1. Tick bite(deer tick, lone star, dog tick?)	Yes	No
2. Rash at bite site(size)	Yes	No
3. Rashes at other sites on body	Yes	No
4. Joint/Muscle pain in feet	Yes	No
5. Swelling in toes, balls of feet	Yes	No
6. Ankle Pain	Yes	No
7. Burning in feet	Yes	No
8. Shin splints	Yes	No
9. Unexplained fevers, sweats, chills	Yes	No
10. Unexplained weight loss or gain	Yes	No
11. Fatigue, tiredness	Yes	No
12. Unexplained hair loss	Yes	No
13. Swollen glands	Yes	No
14. Sore throat	Yes	No
15. Testicular pain/pelvic pain	Yes	No
16. Unexplained menstrual irregularity	Yes	No
17. Unexplained milk production (lactation)	Yes	No
18. Irritable bladder or bladder dysfunction	Yes	No
19. Sexual dysfunction or loss of libido	Yes	No
20. Upset stomach	Yes	No
21. Change in bowel function (constipation, diarrhea)	Yes	No
22. Chest pain or rib soreness	Yes	No
23. Shortness of breath	Yes	No
24. Heart palpitations, pulse skips, heart block	Yes	No
25. Joint pain or swelling	Yes	No
26. Stiffness of the joints, neck, or back	Yes	No
27. Muscle pain or cramps	Yes	No
28. Twitching of the face or other muscles	Yes	No
29. Headache	Yes	No
30. Neck creaks and cracks, neck stiffness	Yes	No
31. Tingling, numbness, burning, or stabbing sensations	Yes	No
32. Facial paralysis, eyelid/facial twitching, Bell's palsy	Yes	No
33. Eyes/Vision: double, blurry, pain, increased floaters	Yes	No
34. Ears/Hearing: buzzing, ringing, ear pain	Yes	No
35. Dizziness, poor balance, increased motion sickness	Yes	No
36. Lightheadedness, wooziness, difficulty walking	Yes	No
37. Tremors	Yes	No
38. Confusion, difficulty in thinking	Yes	No
39. Difficulty with concentration or reading	Yes	No
40. Forgetfulness, poor short term memory	Yes	No
41. Disorientation; getting lost, going to wrong places	Yes	No
42. Difficulty with speech	Yes	No
43. Mood swings, irritability, depression, personality changes	Yes	No
44. Disturbed sleep: too much, too little, early awakening	Yes	No
45. Exaggerated symptoms or worse hangover from alcohol	Yes	No
46. Any history of heart murmur or valve prolapse?	Yes	No
47. Difficulty swallowing	Yes	No
48. Swelling around the eyes	Yes	No
49. Sensitivity to light	Yes	No
50. Difficulty eating	Yes	No
51. Gastritis - stomach problems	Yes	No
52. TMJ	Yes	No
53. Seizure activity	Yes	No