



Patient Demographics:

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

DOB (mm-dd-yyyy): _____ Age: _____ Sex: _____

Phone: Primary: _____ Mobile: _____

Alternate #: _____ Fax (if applicable): _____

Email Address: _____

Emergency contact Name: _____ Relation: _____

Emergency Contact Phone #: _____

Patient Occupation: _____

If Disabled; Previous Occupation: _____

Referring Physician (if applicable) : _____

Referring Physician's Phone #: _____

Primary Care Physician Name: _____

Primary Care Physician Phone #: _____

Doctors who have treated you for Lyme in the past (if applicable)- please include Naturopath's etc.

Please answer the following questions: (If more space is needed please attach separate sheet)

Present well being: Poor Below average Average Fairly good Good

Overall how do you feel today? _____

Have you been diagnosed with Lyme disease? Yes No

If yes, by whom? _____

Most Prominent Symptoms: _____

Are you on antibiotics? Yes No

If yes, please list all antibiotics, dosage and duration: _____

List previous antibiotics, dosage and duration: _____

List other medications, dosage and duration presently taking: _____

Do you take supplements? Yes No If yes, What do you take? _____

List any medication allergies: _____

List any other allergies: _____

Are you pregnant: Yes No If yes, how many months? _____

Have you had problems with previous pregnancies? Yes No

If yes, please explain: _____

Are you taking contraceptives? Yes No

Do you smoke? Yes No If yes, how long?_____Quantity:_____

Do you exercise? Yes No If yes, type:_____

Diet/Eating habits:_____

Outdoor activities?_____

Do you have pets? Yes No If yes, what type?_____

How long?_____ Are they sick? Yes No

If yes, please explain:_____

States Previously Visited:_____

Areas Travelled to outside of United States:_____

History of Tick Bite(s)

Do you remember getting a tick bite? Yes No

If yes, date of bite:_____ City/State where bitten:_____

Was the tick attached to your body when found? Yes No If yes, Where?_____

How long before it was removed? _____

Was the tick identified? Yes No If yes, what type of tick?_____

Symptoms after the tick bite:_____

Generalized date of onset of symptoms?_____

Dermatological

Was there a rash at the bite site? Yes No

If yes, describe the rash: _____

How long after the bite did the rash occur? _____

Duration of rash? _____

Was there a "Bullseye" lesion? Yes No If yes, Duration? _____

Have you been diagnosed with the following?

Please circle all the pertains to you:

ALS

Alzheimer's Disease

Anemia

Asthma

Autism

Bakers Cysts (behind knee)

Bell's Palsy

Bursitis (where? _____)

Carpel Tunnel Syndrome

Depression

Diabetes

PANS/PANDAS

Encephalitis

Fibromyalgia

Iritis

Meningitis

Multiple Sclerosis

Polymyalgia Rheumatica

Prostatitis

Psoriasis/eczema

Stroke (Permanent / Temporary)

Tendonitis

TMJ

Special Children's Questions:

Decreased interest in playing? Yes No

Poor school performance? Yes No

When did he/she start whimpering or whining? _____

Clinical Signs and Symptoms:

Please circle all the pertains to you:

General

Fatigue

Fevers- high/low

Flu-like symptoms

Loss of voice/hoarseness

Loss of appetite

Hair Loss

Sore throats

Heart and Lung

Abnormal Echocardiogram

Chest pain/tightness

EKG abnormalities

Heart attack

Heart Palpitations

Skipped heart beats

Increase blood pressure

Night sweats
Unexplained chills
Unexplained weight change
Other _____

Ear & Eye

Blind spots
Blurred vision
Conjunctivitis
Diminished peripheral vision
Double vision (horizontal/vertical)
Drooping eyelids
Flashing lights
Floaters
Lazy eye
Light sensitivity
Optic atrophy
Pressure behind the eyes
Retinal damage
Uveitis (inflammation of the eye)
Ringing in the ears
Hearing loss/deafness (one or both ears)
Other _____

Musculoskeletal

Muscle pain/aching
Muscle cramps/stiffness
Loss of muscle tone
Jaw pain/stiffness
Back pain/stiffness
Neck pain/stiffness
Joint pain/stiffness
Hand pain/swelling
Elbow pain/swelling
Shoulder pain/swelling
Hip(s) pain/swelling
Knee pain/swelling
Feet/ankle pain/swelling
Leg aches
Other _____

Mitral valve prolapse
Shortness of breath
Cough (dry/productive)
Other _____

Neurological

Abnormal EEG
Anxiety attack
Burning sensation (internal/external)
Change in smell/taste
Confusion
Decreased concentration
Dementia
Depression
Difficulty chewing/swallowing
Dizziness/fainting
Fatigue
Hallucinations
Headache (mild/severe)
Involuntary jerking
Irritability
Memory problems
Meningitis
Mood swings
Motion sickness
Muscle twitching
Nightmares
Numbness (Where? _____)
Obsessive/compulsive behavior
Panic attacks
Paranoia
Partial paralysis (Where? _____)
Personality change
Poor Balance or difficulty walking
Seizures
Sleep disturbance
Suicidal
Tearfulness
Tingling (Where? _____)
Tremors or shaking
Weakness of limbs
Unusual clumsiness
Other _____

Gastrointestinal & Urinary

- Abdominal pain
- Constipation
- Diarrhea
- Diverticulosis
- Irritable bladder
- Liver enlargement
- Nausea
- Spleen enlargement
- Tenderness in abdomen
- Urinary frequency/retention
- Vomiting
- Other_____

Reproductive

- Breast (infections/ discharge)
- Loss of Libido
- Menstrual irregularities
- Pelvic pain
- PMS
- Other_____

Abnormal Lab Results (Circle all that apply and document date and lab)

	Date	Lab
Positive Lyme ELISA/IFA	_____	_____
Positive Lyme Western Blot/Immunoblot	_____	_____
IgG	_____	_____
IgM	_____	_____
Positive Lyme PCR	_____	_____
Positive Lyme Culture	_____	_____
Positive LDA	_____	_____
Other Positive Lyme test(s)	_____	_____
_____	_____	_____
_____	_____	_____
Positive Babesia test	_____	_____
Positive Ehrlichea test	_____	_____
Positive Bartonella test	_____	_____
Positive Mycoplasma	_____	_____

List all other tests to substantiate diagnosis:

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

Other information that would be pertinent to your symptoms or diagnosis: