OHSU FIBROMYALGIA CLINIC QUESTIONNAIRE

Name: ______________________________________ **Age:**_____ **Date of Birth:** _________

Address:____

Home Phone: _____________ **Work Phone:** ________ **Other Phone:** ____________________

FamilyPhysician:_______________________________ **City:**___________________________

Other Physicians:

Chronology of Problem(s)

Date of ***onset*** of FM symptoms: Date of FM diagnosis:
Who first diagnosed FM:
Was the onset related to: An accident? Y N Operation? Y N Major stress? Y N
Infection? Y N Taking medications? Y N Toxic exposure? Y N
Other (describe):____

Did you have pain "all over from day one"? Y N If "***No***", how many areas were painful at onset? ____

Describe sites of ***initial*** pain (eg., neck, left arm, etc.) ___________________________________

Are you right or left handed: R L (please circle)

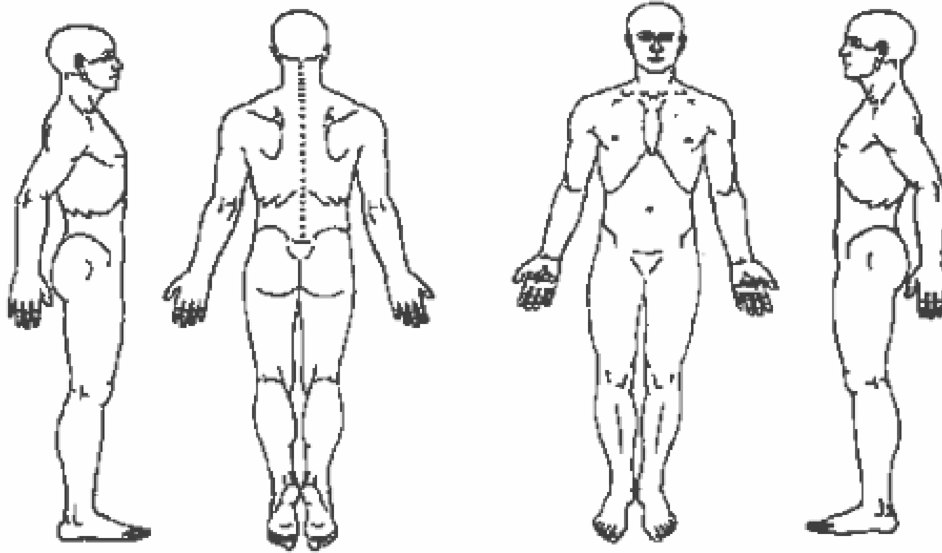
<u>Have you ever had ?</u>

	Diabetes	High blood pressure	Heart disease	Osteoporosis
Arthritis	Ulcers	Kidney disease	Liver disease	Migraine
Alcoholism	Stroke	Psychiatric problems	Epilepsy	Lung disease
Tuberculosis	Sciatica	Drug dependency	Thyroid disease	Hepatitis
Venereal Dis.	AIDS	Fractures	Multiple sclerosis	Endometriosis
Skin disorders	Heart attack	Carpal tunnel	Breast implants	Cancer
Spastic colon	Asthma	Post-traumatic stress	Sjogren's	Lupus

Other diagnoses (describe):

Family History	Age	Health Problems	Alive/Dead	Cause of Death
Father				
Mother				
Brothers				
Sisters				
Children				

Please shade in the areas of <u>usual</u> pain on the figures below and mark the 3 most painful areas (i.e #1, #2 and #3); also note any areas of numbness, tingling etc.



How bad are your best and worse days of pain? (*please place 2 marks on line below*):

No pain at all >_____ _____ _____ _____ _____ _____ _____ _____ _____ _____< Worst possible pain

Please check Symptoms below and mark whether current (C) or past (P):

Symptom	**C or P**		**C or P**
Joint swelling		Poor sleep	
Stiffness		Awaken feeling tired	
Muscle pain		Restless legs	
Muscle weakness		Hands change color in cold	
Pain after exertion		Excessive fatigue for more than 6 mnths	
Frequent headaches		Abdominal cramping	
Chest pain		Constipation	
Swelling or bloating		Abdominal distension	
Difficulty swallowing		Intermittent loose stools	
Daytime sleepiness		Frequent and urgent urination	
Dry or itchy eyes		Impaired logical reasoning	
Light headedness		Loss of memory	
Depressed moods		Excessive anxiety	
Breathlessness		Panic attacks	
Dizziness		Premenstrual tension (PMS)	
Impaired coordination		Tenderness of skin	
Severe fatigue after exercise		Pain that keeps you awake	

Other symptoms:

Personal History

Marital Status (*circle*) Single Married Divorced Widowed No. of Marriages: _____

Height: _______ inches Most recent weight: ________lbs. Weight in high school: _______lbs.

Describe any recent weight change:

Current exercise program:

Past exercise program: (*year stopped:*)

Habits	*Currently*		*In Past*	
Dieting	Yes	No	Yes	No
Alcohol	Yes	No	Yes	No
Tobacco	Yes	No	Yes	No
Marijuana	Yes	No	Yes	No
Amphetamines	Yes	No	Yes	No
Cocaine	Yes	No	Yes	No
Caffeine	Yes	No	Yes	No
Vit. / mineral supplements	Yes	No	Yes	No

Treatments

Please list ***all your current*** medications? __________________ __________________ __________________

__________________ __________________ __________________

__________________ __________________ __________________

__________________ __________________ __________________

__________________ __________________ __________________

__________________ __________________ __________________

__________________ __________________ __________________

List any drug allergies: Have you ever been addicted to any drugs: Y N

What past treatments have you had for this problem? (*circle*)

NSAIDS (eg Ibuprofen)	Opioids	Tranquilizers	Physical Therapy
Ultram or Ultracet	Anti-depressants	Muscle relaxants	Biofeedback
Sleeping Pills	Injections	Exercise	TENS unit
Massage	Acupuncture	Steroids	Orthotics
Psychotherapy	Manipulation	Herbal meds.	Chinese meds.
Ambien	Diet modification	Surgery	
Others:			

List *medications* that have been of help:

List *non-medicinal treatments* that have been helpful:

List all surgeries with year:

____________________________ ____________________________
____________________________ ____________________________
____________________________ ____________________________
____________________________ ____________________________
____________________________ ____________________________
____________________________ ____________________________

Sleep History

Do you get restorative/refreshing sleep?	Yes	No
Do your legs feel "restless or jittery" in the evening?	Yes	No
Do you grind your teeth at night?	Yes	No
Does your bed partner say you snore a lot?	Yes	No
Does your bed partner say you kick your legs while asleep?	Yes	No
Do you have acid reflux at night?	Yes	No
Do you sometimes stop breathing when you snore?	Yes	No
Do you ever awaken gagging or fighting for air?	Yes	No
Do you usually awaken with a headache?	Yes	No
Can you easily fall asleep in the afternoon?	Yes	No
Do you sleep walk?	Yes	No

How many hours do you usually sleep? ________

How many time do you awaken in an average night? _________

In an ***average month*** how many mornings do you *awaken feeling refreshed?* ________

When did you ***last*** get a restorative nights sleep? ___ (years) or ___ (months) or ___ (days)

Work Analysis

Do you ***now*** have a job or career? Y N — Are you retired? Y N

If YES are you currently working? Y N — Name of firm:

If NO what is the date you last worked? / /

Occupations	Description	No. of Years	Reason for Change
Current Position: →	____________	______	_________N.A.________
	____________	______	__________________
Past 3 jobs:	____________	______	__________________
	____________	______	__________________

Is your current position full time?	Y	N	Do you work full time with some restrictions?	Y	N
Do you receive Social Security?	Y	N	Are you filing for Social Security	Y	N
Do you now work part time?	Y	N	Are you filing for Worker's Compensation?	Y	N
Do you work part time with some restrictions?	Y	N	Do you receive a work related pension?	Y	N
Do you receive Worker's Compensation?	Y	N	Are you filing for a work related pension?	Y	N
Are you disabled due to current problem?	Y	N	Are there pending legal claims?	Y	N

How many days of work did you miss last year? ______

Work Environment

Effect of current problem(s) on job efficiency (*circle*) None Mild Moderate Severe ***Disabled***

Describe any significant job stressors:

Describe problems causing loss of efficiency:

Trauma

Date Description

Please list all serious accidents and injuries: ___________ ______________________________________

___________ ______________________________________

___________ ______________________________________

___________ ______________________________________

___________ ______________________________________

___________ ______________________________________

___________ ______________________________________

___________ ______________________________________

___________ ______________________________________

Stressors

Please rate your stress levels in relation to the following areas

	No stress	**Intermittent stress**	**Persistent stress**	**Overwhelming stress**
Marriage:				
Work:				
Parents				
Children:				
Co-workers:				
Financial:				
Health:				
Other:				

Hormonal Issues (female patients)

Have you gone througth the menopause? Y (age:) N
Have you had a total hysterectomy? Y (age:) N
Have you had a partial hysterectomy? Y (age:) N
Are you perimenopausal (i.e. still menstruating but having hot flashes)? Y N
Are you taking Estrogens (eg. Premarin, Ogen, Estrace, Skin patch etc.)? Y N
Are you taking Progestins (eg. Provera)? Y N
Are you taking Birth Control Pills? Y N

Activity Level

Please check each box according to your ***current*** level of ability*:*

Activity	Often do	Sometimes do	Never do	Couldn't do
Read a newpaper				
Shop in a supermarket				
Volunteer your time				
Walk 2 blocks				
Read a novel				
Do a crossword puzzle				
Clean your house				
Socialize with friends				
Cut your toenails				
Climb 2 flights of stairs				
Water an indoor plant				
Blow dry your hair				
Walk 2 miles				

Any **other** major restrictions? (Explain):

What is the major cause for impaired function? *(circle)*

Weakness
Stiffness
Immediate pain
Post exertional pain
Impaired sensation
Poor memory

Restricted motion
Poor concentration
Poor balance
Post exertional fatigue
Poor coordination
Too much stress

Poor vision
Lack of energy
Poor motivation

Other reasons:

Emotional Problems Checklist

SYMPTOM	YES	NO
1. Have you been feeling down, depressed or hopeless in the past month?		
2. Are you bothered by little interest or pleasure in doing things?		
3. Has your appetite changed (eating more or eating less)?		
4. Has your sleep been disturbed (insomnia or over-sleeping)?		
5. Do you feel worthless or guilty?		
6. Do you have sudden or unexpected bouts of anxiety or nervousness?		
7. Do you often feel tense, worried or stressed?		
8. Do you have acute onset of symptoms such as palpitations, shortness of breath, or trembling?		
9. Do you worry about a lot of different things?		
10. Do you avoid places or situations because of anxiety or worry?		
11. Do you have recurrent, persistent or unwanted thoughts or do repetitive behaviors?		
12. Have you been through any significantly stressful periods in the past 6 months?		
13. In your lifetime, have you faced any potentially life-threatening events such as natural disaster, serious accident, physical or sexual assault, military combat or child abuse?		
14. Since you experienced any of these stressors, have you been easily startled?		
Angry or irritable?		
Emotionally numb or detached from your feelings?		
Prone to physical reactions when reminded of the event?		
15. Do you drink alcohol?		
16. Do you use prescription medicines or street drugs to relax, calm your nerves, or get high?		
17. Have you ever made an effort to cut down on your drinking or drug use?		
18. Have you ever been annoyed by people who criticize your drinking or drug use?		
19. Do you ever feel guilty about your drinking or drug use?		
20. Do you ever drink or use drugs to steady your nerves, get rid of a hangover or relieve withdrawal symptoms?		
21. Do you feel that your eating is out of control?		

Symptom Impact:

For questions 1 through 11, please check slot that best describes how you did overall for the *past week*. If you don't normally do something that is asked, cross the question out.

	Always	Most times	Occasionally	Never
1. Go shopping?				
2. Do laundry with a washer and dryer?				
3. Prepare meals?				
4. Wash dishes/cooking utensils by hand?				
5. Vacuum a rug?				
6. Make beds?				
7. Walk several blocks?				
8. Visit friends or relatives?				
9. Do yard work?				
10. Drive a car?				
11. Climb stairs?				

12. Of the 7 days in the past week, how many days did you feel good?

0 1 2 3 4 5 6 7

13. How many days last week did you miss work, including housework, because of fibromyalgia?

0 1 2 3 4 5 6 7

Directions: For the remaining items, mark the point on the line that best indicates how you felt overall for the past week.

14. When you worked, how much did pain or other symptoms of your fibromyalgia interfere with your ability to do your work, including housework?

●___I ___I___I ___I___I ___I ___I ___I ___I___●

No problem with work | Great difficulty with work

15. How bad has your pain been?

●___I ___I___I ___I___I ___I ___I ___I ___I___●

No pain | Worse imaginable pain

16. How tired have you been?

●___I ___I___I ___I___I ___I ___I ___I ___I___●

No tiredness | Very tired

17. How have you felt when you get up in the morning?

●___I ___I___I ___I___I ___I ___I ___I ___I___●

Awoke well rested | Awoke very tired

18. How bad has your stiffness been?

●___I ___I___I ___I___I ___I ___I ___I ___I___●

No stiffness | Very stiff

19. How nervous or anxious have you felt?

●___I ___I___I ___I___I ___I ___I ___I ___I___●

Not anxious | Very anxious

20. How depressed or blue have you felt?

●___I ___I___I ___I___I ___I ___I ___I ___I___●

Not depressed | Very depressed

Unpleasant Leg Sensations

Do you have an unpleasant, restless feeling in your legs? ____ YES _____ NO

If yes, please answer the following questions.

1. Please grade these feelings in the legs as _____ mild _____moderate _____severe

2. When do you get these unpleasant feelings (check as appropriate):
   _____ in bed at night
   _____ during or after prolonged sitting (such as watching a movie or riding a car)
   _____ other time (describe___________________________________).

3. Do you have an urge to move your legs during these unpleasant feelings? ____ YES _____ NO

4. Are the unpleasant feeling relieved by movements? ____ YES _____ NO

5. Do you have any other kinds of feelings in your leg besides ‘unpleasant and restless?’ _____ YES _____NO.
   If yes, check as appropriate: _____ feeling of insects crawling, _____ feeling of worms writhing
   _____ tingling or numbness, _____ pins and needles

Past Investigations

Have you had any of the following special investigations? *(please check)*

Bone or Joint X Rays	Myelogram	Electrocardiogram (ECG)
Radioactive joint scan	Sleep study (polysomnogram)	Echocardiogram (ECHO)
MRI or CT of brain	Mammogram	Laparoscopy
MRI or CT of spine	Electro-encephalogram (EEG)	Arthroscopy
MRI of a joint	Electrical nerve tests (EMG or NCV)	Swallowing studies
Muscle biopsy	Lung function tests (spirometry)	HIV testing
Lymph gland biopsy	CT or MRI of parotid gland	Skin biopsy
Salivary gland biopsy	CT or MRI of chest or abdomen	Ophthalmologic examination
Lumbar puncture	Osteoporosis testing	Angiogram
Balance studies	Abdominal ultrasound	Exploratory surgery
Bladder studies	Schirmer's testing (for dry eyes)	Upper or lower G.I. (endoscopy)
Hearing tests (audiometry)	Visual or auditory evoked potentials	Psychological testing

Any **other** special studies? *(explain):*

Have you had blood tests within last year? Y N Have you had a chest X ray within last year? Y N

Please sign and date: ___________________________________ _________
Signature *Date*