Health History Questionnaire
Murakami Centre for Lyme

Please fill out this information as best you can. When complete, fax to our toll free number at 1-866-259-2320.
Your history will then be reviewed and you will receive a call back.

Please Note: Due to the large volume of calls, emails and faxes we receive, we appreciate your patience with this process. All consultations are dealt with in a priority sequence.
Thank you for your understanding.

Patient Information **Please Print**

Last Name:	**Sex:** ☐ **M** ☐ **F**
First Name:	**DOB:** (MM/DD/YYYY)
Address:	
City:	**Province/State:**
Country:	**Postal/Zip:**
Phone (Day):	**Phone (Eves):**
Email (most accessible)**:**	
Current Family Physician:	
Referring Physician (if applicable)**:**	
Date of Lyme Diagnosis (if applicable)**:**	

Personal Health History:

Childhood Illnesses: __Measles __Mumps __Rubella __Chicken Pox __Polio
__Rheumatic Fever __Scarlet Fever __ Other:____________________

Medical Illnesses:

Illness:	Age at Onset:
__Diabetes	_______
__Hypertension	_______
__Heart Disease	_______
__Asthma	_______
__Cancer	_______
__Genetic Defects	_______
__Osteoarthritis	_______
__Gout	_______
__Epilepsy	_______
__Bleeding Disorder	_______
__Severe Infections	_______
__Other:___________	_______
__________________	_______
__________________	_______
__________________	_______

Work Health:
Has patient been exposed to chemicals at work?

___Yes

Describe:
____
____

Frequency:
____

___No

Has patient ever had a blood transfusion?: ____No ___Yes Date: mm/dd/yyyy

Please List Any Surgeries:

Surgery	Reason	Date

Please list any other hospitalizations:

List of Medications: Please list all PAST and CURRENT prescriptions

Name of Drug	Strength	Frequency Taken	Date Started	Reaction if Any

Health & Personal Relationships:

Relationships:

__Single
__Married How Long?: _________ Marital Stress Level (on a scale of 1-10)_______________
__Separated How Long?: _________
__Children How Many?: _________ Ages:____

Health Issues With Children:

Allergies___

Cancers/Leukemia___

Behavioral Problems High___ Medium___ Low___

Emotional Problems High___ Medium___ Low___

Personal Emotional Development: (please describe)

Family Health History:

Father: Living: ____ Age:______
Deceased: ____ Age:______

Health History:

Mother: Living: ____ Age:______
Deceased: ____ Age:______

Health History:

Siblings: How Many?: ____ How Many Still Living? : ______

Health History For All:

Patient Schooling History:

Were there behavioral problems at school?: Yes____ No____
Describe:

Roots:

Place of Birth: ____

Where Patient Grew Up:

Personal Emotional Development: (please describe)

Family Health History:

Father: Living: ____ Age:______
Deceased: ____ Age:______

Health History:

Mother: Living: ____ Age:______
Deceased: ____ Age:______

Health History:

Siblings: How Many?: ____ How Many Still Living? : ______

Health History For All:

Lyme Symptoms Checklist:

The Tick Bite: Date Bitten (if known): (mm/dd/yyyy)

Geographical Location Where Bitten: (province, State, etc): ___________________________________

Rash at Bite Site? Yes____ No ____ Describe: ____

Rashes on other parts of body? Yes:____ No ____

Describe:

Rash basically circular and spreading out/generalized? Yes ____ No ____

Raised rash, disappearing and recurring? Yes ____ No ____

Head, Face, Neck: check all that apply

- ☐ Unexplained hair loss
- ☐ Headache, mild or severe
- ☐ Seizures
- ☐ Pressure in Head
- ☐ White Matter lesions in head
- ☐ Twitching of facial or other muscles
- ☐ Facial paralysis (Bell's Palsy)
- ☐ Tingling of nose (tip), tongue, cheek or facial flushing
- ☐ Stiff or painful neck
- ☐ Jaw or pain stiffness
- ☐ Unexplained dental problems
- ☐ Sore throat, clearing throat a lot, phlegm, hoarseness, runny nose
- ☐ Eyes, Vision double or blurry, increased floating spots
- ☐ Pain in eyes, or swelling around eyes
- ☐ Oversensitivity to light
- ☐ Flashing lights/peripheral waves/ phantom images in corners of eyes

Ears, Hearing: check all that apply

- ☐ Decreased hearing in one or both ears, plugged ears
- ☐ Buzzing in ears
- ☐ Pain in ears, oversensitivity to sound
- ☐ Ringing in one or both ears

Digestive/Excretory: check all that apply

- ☐ Diarrhea
- ☐ Constipation
- ☐ Irritable Bladder (trouble stopping/starting), Interstitial cystitis
- ☐ Upset stomach (nausea or pain), or GERD (gastro esophageal reflux disease)

Musculoskeletal System: check all that apply

- ☐ Bone pain, joint pain or swelling, carpal tunnel syndrome
- ☐ Stiffness of joints, back, neck, tennis elbow
- ☐ Muscle pain or cramps (Fibromyalgia)

Respiratory/Circulatory: check all that apply

- ☐ Shortness of breath, can't get full/satisfying breath, cough
- ☐ Chest pain or rib soreness
- ☐ Night sweats or unexplained chills
- ☐ Heart palpitations or extra beats
- ☐ Endocarditis
- ☐ Heart blockage

Neurological System: check all that apply

- ☐ Tremors or unexplained shaking
- ☐ Burning or stabbing sensations in the body
- ☐ Fatigue
- ☐ Chronic Fatigue Syndrome
- ☐ Weakness, peripheral neuropathy or partial paralysis
- ☐ Pressure in the head
- ☐ Numbness in body, tingling or pinpricks
- ☐ Poor balance, dizziness, difficulty walking, increased motion sickness
- ☐ Light-headedness, wooziness

Psychological Wellbeing: check all that apply

- ☐ Mood swings, irritability, bi-polar disorder
- ☐ Unusual depression
- ☐ Disorientation, getting or feeling lost
- ☐ Feeling as if you are losing your mind
- ☐ Over emotional reactions, crying easily
- ☐ Too much sleep, insomnia
- ☐ Difficulty falling or staying asleep
- ☐ Narcolepsy, sleep apnea
- ☐ Pain attacks, anxiety

Mental Capability: check all that apply

- [ ] Memory loss, short or long term
- [ ] Confusion, difficulty in thinking
- [ ] Difficulty with concentration or reading
- [ ] Speech difficulty, slurred or slow
- [ ] Stammering speech
- [ ] Forgetting how to perform simple tasks

Reproduction & Sexuality: check all that apply

- [ ] Loss of sex drive
- [ ] Sexual Dysfunction
- [ ] Unexplained menstrual pain, irregularity
- [ ] Testicular or pelvic pain

General Wellbeing: check all that apply

- [ ] Unexplained weight gain/loss
- [ ] Extreme fatigue
- [ ] Swollen glands, lymph nodes
- [ ] Unexplained fevers, high or low grade
- [ ] Continual infections (sinus, kidney, ear, eye, etc)
- [ ] Symptoms seem to change, come and go
- [ ] Pain migrates (moves) to different parts of the body
- [ ] Early on, flu-like symptoms after which, never felt well
- [ ] Allergies, chemical sensitivities
- [ ] Increased effect from alcohol and possible worse hangovers

Specialist History:

select all that apply

Specialist	Diagnosis	Considered Lyme?
☐ Cardiologist		
☐ Rheumatologist		
☐ Internist		
☐ Gastroenterologist		
☐ Psychologist/Psychiatrist		
☐ Endocrinologist		
☐ Neurologist		
☐ Gynecologist		
☐ Oncologist		
☐ Ophthalmologist		
☐ Infectious Disease		
☐ Naturopath		

Tests Completed By Prior Doctors/Specialists:

- ☐ MRI
- ☐ X Ray
- ☐ Thyroid
- ☐ Serology
- ☐ EKG
- ☐ CATT

Lyme Tests Completed by Prior Doctors/Specialists:

In Canadian Labs: (Through CDC) Ordered by Whom:______________________________

	Name of Test	Result	Diagnosis	Date
☐	C6 ELISA			
☐	ELISA			
☐	Western Blot			
☐	PCR			

In US Labs: Through:_______________Ordered by Whom:_________________________

	Name of Test	Result	Diagnosis	Date
☐	CD57 Plus			
☐	C6 ELISA			
☐	ELISA			
☐	Western Blot			
☐	PCR Serological			
☐	PCR Urine			
☐	PCR Spinal Tap			

Further Notes:

Drug Treatment Therapy (Lyme Specific Only):

Definitions: IV (intra venous) IM (intra muscular)

	Name of Drug	Length of Therapy	Start Date	End Date	Side Effects
☐	Tetracycline				
☐	Doxycycline				
☐	Amoxycillin				
☐	Ceftin				
☐	Biaxin				
☐	Ketex				
☐	Zithromax				
☐	Plaquanel				
☐	Tinidazole				
☐	Metrandazole				
☐	IV Ceftriaxone Or other: _____________ *Gall Bladder History?_____				
☐	IV Penicillin Allergy?_____				
☐	IM Ceftriaxone *Gall Bladder History?_____				
☐	IM Penicillin Allergy?_____				

**denotes any gall bladder history either personally or with blood relatives.* Please explain:

____

____

Therapy Background:

Therapies Received: Ordered By Which Doctor/Specialist? (cardiologist, etc)

Oral ______________________________

Intra Venous (IV)
PICC/Saline/Heparin Lock ______________________________

Intra Muscular (IM) ______________________________

Alternative Methods of Treatment Received/Receiving:

Treatment	Received	Receiving	Start Date	End Date
Special Diet				
Hyperthermia Treatment				
Chelation Therapy				
Ultraviolet Blood Dialysis				
Peroxide Injections				
Bee Venom Injections				
Hyperbaric Oxygen Therapy				
Salt & Vitamin C Therapy				
Rife Machine				
Marshall Protocol				
Herbal Therapies Please List:				
Others:				

Which, if any, have given you the most relief?