Laboratory and tests at first visit and at most recent visit

- CBC with differential, ESR;
- Blood chemistry/metabolic panel: glucose, BUN, creatinine, total protein, albumin, globulin, ALT, AST, alk phos, Ca, PO4, electrolytes;
- C-Reactive Protein, ANA, Rheumatoid factor;
- Endocrine tests: TSH, free T4, other if performed;
- Urine Analysis;
- Other: Hyperventilation test, Simplified Orthostatic test or Tilt test, ECG, Echocardiography, Sleep study, etc **Add a column for normal range**

CBC and blood chemistry	Date (earliest) …………… Value	Date (most recent) …………… Value	Comment
ESR			
CBC			
…..			
…..			
…..			
…			
Blood chemistry	Date (earliest) …………… Value	Date (most recent) …………… Value	Comment

Urine	Date (earliest) …………… Value	Date (most recent) …………… Value	Comment

Please remember to enter the measuring units for the tests (e.g., very important for CRP)

Immunology tests	Date first________ Result	Date most recent ______; Results	Comments
CRP			
ANA titer			
RF			

Please remember to enter the measuring units for the tests

Endocrine tests	Date first________ Result	Date most recent ______; Results	Comments
TSH			
Free T4			
DHEAS			
Other/specify below			

Additional tests:
List them first:
1.
2.
3.
4.
5.

Then, abstract from record or provide a photocopy of the test results (with name of subject deleted).

Results from additional tests.

1.

2. ______

3. ______

4. ______

5. ______

Please add more pages if needed!

Subject ID: ____________
Abstraction Date____/____/________

Demographic Information

Month of Birth: ____ Year of Birth___________

Circle the correct answer (specify if “other is circled”)

Sex: Male=1; Female=2

Race: White=0; Black/African American=1; American Indian=2; Asian/Pacific Islander=3;
Other=4; Two or more races=5; Missing=99

Ethnicity: Hispanic=0; Non-Hispanic=1

Marital status:
Married=1; Member of unmarried couple=2; Separated=3; Divorced=4; Widowed=5;
Never married=6, Missing=99

Employment:
Full-time=1; Part-time=2; Not employed=3; Missing=99
If not employed, reason: Retired=1; Laid off=2; Disabled=3; Homemaker=4;
Student/training = 5; other (specify) ______________ =6; Missing=99

Currently receiving unemployment benefits: Yes=1; No=2

Number of visits to this clinic within last 12 months: _________

Miss work or school because of illness: Yes=1; No=2; Missing=99

Currently insured: Yes=1; No=2; Missing=99
If insured, type of insurance: Medicare=1; Medicaid=2; Insurance through work=3;
Insurance through someone else= 4; Missing=99

Education:
Less than high school=1; High school graduate=2; College graduate=3; Post college=4;
Missing =99

FAMILY HEALTH HISTORY

Indicate by checking "YES" or "NO" if any blood relatives have ever had any of the listed health conditions. Include patient's parents, siblings (full and half), and children.

		No	Don't Know	**Yes**			**Comments**
				Relative who has the condition and their current age or their age at death (marked as YY*)			
	Health Problems			Mother (M_ age), father (F_age)	Brothers (Br_age) and sisters (Si_age)	Your children: son (S_age), daughter (D_age)	
1.	Allergies (specify what type): nasal, skin (Eczema), asthma, other	☐ 2	☐ 8				
2.	Mood/Affective disorders (e.g. depression, dysthymia, bipolar disorder) (specify comments)	☐ 2	☐ 8				
3.	Anxiety disorders (e.g, acute stress disorder, anxiety, generalized anxiety disorder, obsessive-compulsive disorder, panic disorder, phobia, PTSD, or social phobia) (specify in comments)	☐ 2	☐ 8				
4.	Substance abuse disorder (alcohol, drugs)	☐ 2	☐ 8				
5.	Non-affective psychosis (NAP) (e.g. schizophrenia, schizophreniform disorder, schizoaffective disorder, delusional disorder) (specify in comments)	☐ 2	☐ 8				
6.	Seizures, convulsions, epilepsy	☐ 2	☐ 8				
7.	Parkinson's disease	☐ 2	☐ 8				
8.	Alzheimer's disease or other dementia	☐ 2	☐ 8				
9.	Multiple sclerosis	☐ 2	☐ 8				
10.	Rheumatoid arthritis, Systemic lupus, or autoimmune disease	☐ 2	☐ 8				
11.	Fibromyalgia	☐ 2	☐ 8				
12.	MUS (e.g. IBS, MCS, TMD or even migraine) (specify in comments)	☐ 2	☐ 8				
13.	Chronic fatigue syndrome	☐ 2	☐ 8				
14.	Bleeding problems	☐ 2	☐ 8				
14.	Anemia (sickle cell, thalassemia)	☐ 2	☐ 8				
15.	Hypertension	☐ 2	☐ 8				
16.	High cholesterol or other lipids	☐ 2	☐ 8				
17.	Stroke	☐ 2	☐ 0				
18.	Heart attack (coronary)	☐ 2	☐ 8				
19.	Lung or breathing problems	☐ 2	☐ 8				
20.	Thyroid or other hormone/endocrine disorder (specify)	☐ 2	☐ 8				
21.	Diabetes (indicate if juvenile, Type I, or adult onset; Type II, insulin or noninsulin, dependency)	☐ 2	☐ 8				
22.	Weight problems; e.g., obesity or anorexia (specify)	☐ 2	☐ 8				
23.	Metabolic disorder (specify)	☐ 2	☐ 8				
24.	Stomach problems, or ulcers, or intestinal problems (irritable bowel disease, etc.)	☐ 2	☐ 8				
25.	Kidney problems (specify)	☐ 2	☐ 8				
26.	Osteoarthritis or rheumatoid arthritis (specify)	☐ 2	☐ 8				
27.	Muscle disease or weakness (for example: muscle dystrophy, other)	☐ 2	☐ 8				
28.	Neuromuscular disorder (specify)	☐ 2	☐ 8				
29.	Cancer (type, site, age when diagnosed)	☐ 2	☐ 8				
30.	Infertility	☐ 2	☐ 8				
31.	Polycystic ovaries	☐ 2	☐ 8				
32.	Endometriosis	☐ 2	☐ 8				
33.	Other gynecologic condition (specify)	☐ 2	☐ 8				

34.	Birth defects (specify what defect)	☐ 2	☐ 8				
35.	(I) Other condition (specify)	☐ 2	☐ 8				
36.	(II) Other condition (specify)	☐ 2	☐ 8				
37.	(III) Other condition (specify)	☐ 2	☐ 8				
38.		☐ 2	☐ 8				

~The End~

Subject ID: ___________
Abstraction Date___/___/_______

History of ME/CFS abstraction form

Date of CFS Diagnosis	
Approximate **Age** at Time of CFS Diagnosis	
Criteria Used to Define CFS	recorded /not recorded
Date of CF Diagnosis (if CFS diagnosis not given)	
Approximate **Age** at Time of Chronic Fatigue Diagnosis	
Approximate **Date** of Fatigue Onset (YEAR-MM)	
Approximate **Age** at Time of Fatigue Onset	

Severity of illness ______________________________

Fatigue	Date of onset (YEAR-MM)
Chronic Fatigue Lasting 6 Months or More	

Symptoms	Date of onset (YEAR-MM) or not available (NA)
Impaired memory or concentration, forgetfulness affecting function	
Sore throat	
Tender cervical or axillary lymph nodes	
Muscle pain/aches	
Multi-joint pain	
New headaches or severe headaches	
Un-refreshing/ Non-restorative sleep	
Post-exertion malaise (that lasts at least 24 hours)	
Chills	
Fever	
Depression	
Diarrhea	
Eyes extremely sensitive to light	
Nausea	
Numbness or tingling	
General weakness	
Shortness of breath	
Sinus or nasal symptoms	
Stomach or abdominal pain	
Other (specify) ________________________	
Other (specify) ________________________	

Fatigue or symptoms significantly affect daily activities or work		no
		yes
		not recorded

Subject ID: _____________
Abstraction Date____/____/________

IMMUNIZATION AND INFECTION HISTORY

1. History of allergies Yes No Don't know

2. Received the following immunizations or had the disease

Pneumococcal (for pneumonia)	Yes	No	Don't know
Hepatitis B	Yes	No	Don't know
Hepatitis A	Yes	No	Don't know
Measles	Yes	No	Don't know
Mumps	Yes	No	Don't know
Rubella	Yes	No	Don't know
Polio	Yes	No	Don't know
Varicella (for chicken pox)	Yes	No	Don't know

Infections

3. Does the patient have frequent infections as cited in medical records?

Yes → If Yes, Go to question 3a.
No
Don't know

3a. please describe the infections

Date (Month/year)	Select the type of infections				
	Cold	Other viral infections	Bacterial	Fungal	Don't know

CFS Multisite Clinical Assessment

Medical History Form

Subject ID__________________

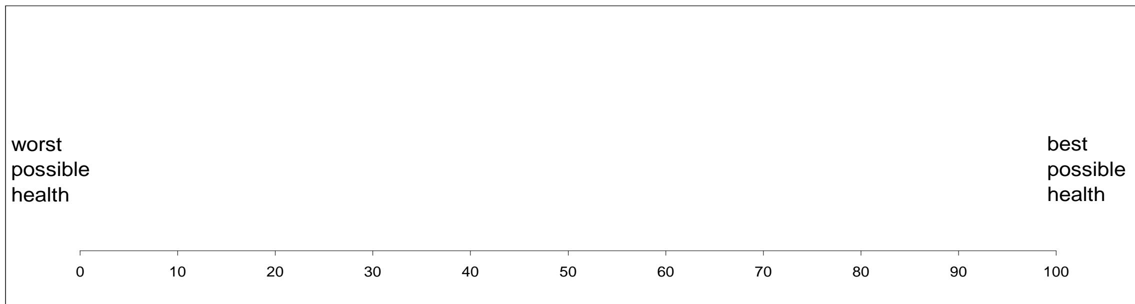
Date of record abstraction: _____/_____/______

Date of review by subject: _____/_____/______

Part A. To be completed by the patient at the time of clinical evaluation.

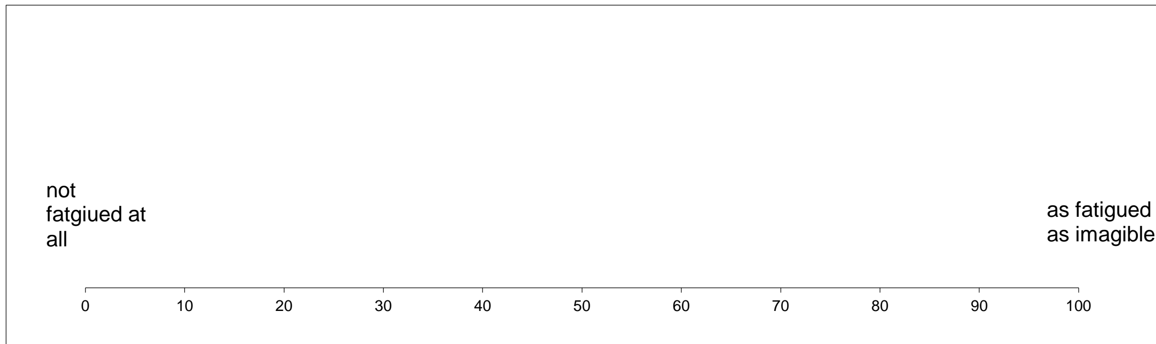
1. Now I would like you to think of a scale between 0 and 100, where 0 is the worst health you can imagine and 100 is the best you can imagine.

   Think about your overall health today. What number between 0 and 100 best describes your health today? Please place an "X" on the scale below.



2. Now I would like you to think about a scale between 0 and 100, where 0 is not being fatigued at all and 100 is being the most fatigued you can imagine.

   Think about how tired you feel today. What number between 0 and 100 best describes how tired you feel today? Please place an "X" on the scale below.



Please list your health problems below (for the third column-- circle the correct answer).

Problem/Complaint/Concern	**When did this problem start?**	**Do you still have this health problem?**
1.	____ / ______ (Month/Year)	___Yes ___No
2.	____ / ______ (Month/Year)	___Yes ___No
3.	____ / ______ (Month/Year)	___Yes ___No
4.	____ / ______ (Month/Year)	___Yes ___No
5.	____ / ______ (Month/Year)	___Yes ___No
6.	____ / ______ (Month/Year)	___Yes ___No
7.	____ / ______ (Month/Year)	___Yes ___No
8.	____ / ______ (Month/Year)	___Yes ___No
9.	____ / ______ (Month/Year)	___Yes ___No

From the time these problems began until now, are they better or worse? Check the correct box below.

	Better	Worse	The Same		Better	Worse	The Same
Problem 1.				Problem 6.			
Problem 2.				Problem 7.			
Problem 3				Problem 8			
Problem 4.				Problem 9.			
Problem 5.							

In the past year, how many colds, bouts of flu or upper respiratory infections have you had?

(Indicate if continuous) ____

____

Circle the number of hours per day that you spend in vertical/horizontal activity.

Hours vertical/24 hours 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15+

(average time with feet on the floor---sitting, standing or walking)

Hours horizontal/24 hours 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15+

(average time with feet up--- resting in recliner, feet up, napping, sleeping in bed)

Level of physical activity

During a typical **7-day period** (a week), how many times, on average, do you do the following kinds of exercise for **more than 15 minutes during your leisure time**? Also, for how many minutes do you usually do each kind of exercise?

		Times Per Week	**Minutes Each Time**
	STRENUOUS EXERCISE (HEART BEATS RAPIDLY) (examples: running, jogging, soccer, squash, hockey, basketball, football, judo, roller skating, vigorous swimming, vigorous long distance bicycling)		
	MODERATE EXERCISE (NOT EXHAUSTING) (examples: fast walking, lifting weights, baseball, tennis, easy bicycling, volleyball, badminton, easy swimming, popular and folk dancing, gardening)		
	MILD EXERCISE (MINIMAL EFFORT) (examples: easy walking, yoga, archery, fishing from river bank, bowling, horseshoes, golf, snow-mobiling)		

If you are you currently employed, what is the activity level of your job?

- ☐ 1 Not currently employed
- ☐ 2 Very active-one that involves heavy lifting, digging, strenuous labor (for example, construction labor, landscaping, lumberjack)
- ☐ 3 Active-one that involves walking and/or light lifting (for example, carpenter, mail delivery, janitor)
- ☐ 4 Moderately active-one that combines standing and walking (for example, security guard, mechanic, nursing)
- ☐ 5 Inactive-one that combines sitting and standing (for example, cashier, sales, teaching)
- ☐ 6 Very inactive-one that involves mostly sitting (for example, desk job, telemarketing, truck driver)

Have you ever experienced significant weight gain or weight loss (more than 7 lb) ?

In the last 6 months	Gain	Yes ____ , lb_______	No
	Loss	Yes ____ , lb_______	No
In the last 5 years	Gain	Yes ____ , lb_______	No
	Loss	Yes ____ , lb_______	No

If you had specific weight changes, how many times did that happen after age 21? ____________

Smoking

If you ever smoked regularly, for six months or longer, enter the age when you started?

From age ___ till age _____; From age _____ till age _____ ; From age _____ till age _____

How many cigarettes would you say you smoke(d) per day? _________ cigarettes per day

Do you currently smoke cigarettes? (circle one) Yes No

Part B. To be abstracted from medical record and carefully reviewed for accuracy by the patient. Patient needs to add the information that was not in the medical record or was in complete.

Please describe major childhood and adolescent illnesses you remember (such as diagnosed by a physician)

Significant health illnesses/conditions *before* age 21	**Age when condition occurred**
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	

Physical and mental health conditions as an adult—*after age 21*	**Age at onset**
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

Physical and mental health conditions as an adult—*after age 21*	**Age at onset**
11.	
12.	

List below all surgeries, major injuries, and hospitalizations including the age at the time of the event (Examples: tonsillectomy, broken bone, a heart attack, pneumonia, appendectomy, etc.)

Description of Injuries/Surgeries/Hospitalizations	**Age for each one**
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	
14.	
15.	
16.	
17.	
18.	
19.	
20.	
21.	

Description of Injuries/Surgeries/Hospitalizations	Age for each one
22.	
23.	
24.	
25.	

Allergies and sensitivities

	Allergies to **medicines** (list drugs)	Yes	No	Type of reaction (rash, swelling, bronchospasm, other-describe)	Age at onset
1.					
2.					
3.					
4.					
5.					
6.					
7.					

	Allergies or intolerance to **foods** (list specific foods)	Yes	No	Type of reaction (rash, swelling, diarrhea, other-describe)	Age at onset
1.					
2.					
3.					
4.					
5.					
6.					
7.					

	Chemical sensitivities (list specific chemicals/ substances)	Yes	No	Type of reaction (describe, e.g., headache)	Age at onset
1.					
2.					
3.					
4.					
5.					
6.					
7.					

Condition/ Illness	Yes	No	Don't know	Age at onset	Still Present?	Comment/ details
ENT conditions						
Frequent sinus infections/ stuffy nose/ rhinitis/ post nasal drip						
Frequent sore throat or pharyngitis						
Frequent ear infections						
Frequent mouth sores						
Dry mouth						
Bleeding gums or gum recession						
Cardiovascular						
Irregular heart beat or palpitations					__Yes __No	
Chest pain/ angina or coronary artery disease					__Yes __No	
Heart attack					__Yes __No	
Shortness of breath/ heart condition that limits ability to walk					__Yes __No	
Heart failure of fluid in your lungs					__Yes __No	
Heart murmur					__Yes ___No	
Malfunctioning heart valves					__Yes ___No	
High blood pressure (hypertension)					__Yes ___No	
Low blood pressure					__Yes ___No	
Feet or hands get cold very easily					__Yes ___No	
Orthostatic intolerance or POTS					__Yes ___No	
Stroke					__Yes ___No	
Phlebitis or deep venous thrombosis					___Yes __No	
Peripheral vascular disease					___Yes __No	
Hemorrhoids					___Yes __No	
Other (specify) ________________					___Yes __No	
Other (specify) ________________					___Yes __No	
Chest						
Asthma					___Yes __No	
Chronic bronchitis or COPD					___Yes __No	
Emphysema					___Yes __No	
Pneumonia					___Yes __No	
Tuberculosis					___Yes __No	
Other chronic lung condition					___Yes __No	
Endocrine and metabolic						
Adrenal insufficiency					___Yes __No	
Overactive adrenal gland (Cushing disease)					___Yes __No	
Diabetes (type 1 or 2)					___Yes __No	

Condition/ Illness	Yes	No	Don't know	Age at onset	Still Present?	Comment/ details
Hypoglycemia (low blood sugar)					___Yes __No	
Thyroid conditions: a. overactive (hyperthyroidism)					___Yes __No	
b. underactive (hypothyroidism)					___Yes __No	
Is thyroid condition under control?					___Yes __No	
High cholesterol					___Yes __No	
High triglycerides					___Yes __No	
Gastrointestinal						
Poor or excessive appetite (circle)					___Yes __No	
Heartburn or reflux (GERD)					___Yes __No	
Gastritis					___Yes __No	
Stomach or duodenal ulcer					___Yes __No	
Enteritis					___Yes __No	
Colitis					___Yes __No	
Inflammatory bowel disease a. Crohn's Disease b. Ulcerative colitis					 ___Yes __No ___Yes __No	
Irritable Bowel Syndrome					___Yes __No	
Malabsorption or chronic diarrhea					___Yes __No	
Celiac disease (celiac sprue)					___Yes __No	
Constipation					___Yes __No	
Pancreatitis					___Yes __No	
Gallstones or gallbladder infection					___Yes __No	
Liver cirrhosis					___Yes __No	
Chronic hepatitis (type A,B or C)					___Yes __No	
Acute hepatitis (type A,B or C)					___Yes __No	
Other liver damage					___Yes __No	
Blood disorders						
Anemia requiring treatment or blood transfusions					___Yes __No	
Mononucleosis					___Yes __No	
Easy bruising					___Yes __No	
Enlarged lymph nodes (specify which) ________________________						
Thrombocytopenia					___Yes __No	
Sickle cell trait					___Yes __No	
Sickle cell disease						
Malaria						
Other blood disorders (specify)						

Condition/ Illness	Yes	No	Don't know	Age at onset	Still Present?	Comment/ details
___________________________						
Neurological						
Dizziness or vertigo					___Yes __No	
Migraine /Headaches					___Yes __No	
Number of headaches per month ____						
Fainting					___Yes __No	
Loss of consciousness (not fainting)					___Yes __No	
Inability to recall events or names					___Yes __No	
Meningitis or encephalitis					___Yes __No	
Peripheral neuropathy					___Yes __No	
Multiple sclerosis					___Yes __No	
Neuralgia					___Yes __No	
Seizure Disorder					___Yes __No	
Weak or paralyzed muscles (specify which) ___________________					___Yes __No	
Stroke					___Yes __No	
Head injuries (describe in section 1)						
Guillain-Barre syndrome					___Yes __No	
Parkinson's disease					___Yes __No	
Restless leg syndrome					___Yes __No	
Psychological						
Inability to relax					___Yes __No	
Anorexia					___Yes __No	
Bulimia					___Yes __No	
Delusions					___Yes __No	
Dementia					___Yes __No	
Depression					___Yes __No	
Drug abuse					___Yes __No	
Alcohol abuse / dependency					___Yes __No	
Maniac depressive or bipolar disorder					___Yes __No	
Rheumatological						
Arthritis					___Yes __No	
Fibrositis or Fibromyalgia (circle one)					___Yes __No	
Gout					___Yes __No	
Systemic Lupus Erythematosus					___Yes __No	
Lyme Disease					___Yes __No	
Osteoarthritis					___Yes __No	
Psoriasis					___Yes __No	

Condition/ Illness	Yes	No	Don't know	Age at onset	Still Present?	Comment/ details
Rheumatic fever					___Yes __No	
Rheumatoid arthritis					___Yes __No	
Sjogren's syndrome					___Yes __No	
Temporo-mandibular joint syndrome					___Yes __No	
Autoimmune disease Specify: _________________					___Yes __No	
Tumors						
Malignant tumors (including lymphoma or leukemia) Specify: ___________________________					___Yes __No	
Benign tumors. Specify: ____________________________					___Yes __No	
Urogenital						
Genital herpes					___Yes __No	
Interstitial Cystitis					___Yes __No	
Urinary tract infection(s)					___Yes __No	
Kidney or bladder (urinary) stone					___Yes __No	
Trouble emptying your bladder					___Yes __No	
Need to urinate (pee) frequently, burning sensation or pain					___Yes __No	
Kidney Failure					___Yes __No	
Other kidney problem (specify) _________________________					___Yes __No	
Number of times going to the bathroom at night ____x						
Female conditions only						
Age at first menstrual period ____				____		
Duration of a typical menstrual periods (if menopausal, still answer for past periods) ___ (days)						
Interval between menstrual periods from ___ to ____ days						
Heavy/excessive menstrual bleeding					___Yes __No	
Irregular periods					___Yes __No	
Bleeding between periods					___Yes __No	
Missing periods (other than pregnancy)					___Yes __N	
Endometriosis					___Yes __No	since age _____
Pelvic inflammatory disease					___Yes __No	
Premenstrual syndrome					___Yes __No	
Number of pregnancies = ____					___Yes __No	

Condition/ Illness	Yes	No	Don't know	Age at onset	Still Present?	Comment/ details
Number of miscarriages = ____						
Infertility					___Yes __No	
In menopause since age _____				_____		
Hysterectomy (partial or total)					At age_______	
Ligation (tubes tied) or removal of tubes, circle the right one					At age _____	
Removal of ovaries--one or two (specify) ______					At age _______	
Other gynecologic conditions (specify) ___________________					___Yes __No	
Vaginal yeast infection					___Yes __No	
Other genital infections (specify) ___________________					___Yes __No	
Male conditions only						
Epididymitis					___Yes __No	
Prostate enlargement or prostatitis					___Yes __No	
Varicocele					___Yes __No	
Impotence					___Yes __No	
Other problems (specify) ____________					___Yes __No	
Skin problems						
Eczema					___Yes __No	
Psoriasis					___Yes __No	
Rashes					___Yes __No	
Other (describe)					___Yes __No	
Other (describe)					___Yes __No	
Miscellaneous						
HIV infection					___Yes __No	
Chronic Fatigue Syndrome					___Yes __No	
Oral herpes (cold sores)					___Yes __No	
Glaucoma					___Yes __No	
Multiple Chemical Sensitivity Syndrome					___Yes __No	
Environmental hypersensitivity					___Yes __No	
Sleep Apnea					___Yes __No	
Narcolepsy					___Yes __No	
Other sleep disorder: (specify___________)					___Yes __No	
Organ transplant (specify) _______					___Yes __No	
Other condition_1:					___Yes __No	

Condition/ Illness	**Yes**	**No**	**Don't know**	**Age at onset**	**Still Present?**	**Comment/ details**
Other condition_2:					___Yes __No	
Other condition_3:					___Yes __No	
Other condition_4:					___Yes __No	
Other condition_5:					___Yes __No	
Other condition_6:					___Yes __No	
Other condition_7:					___Yes __No	
Other condition_8:					___Yes __No	
Other condition_9:					___Yes __No	

Subject ID _____________

Please list ALL medications (including prescription drugs, over the counter drugs, dietary supplements (including vitamins), herbal, homeopathic and health food preparations) taken routinely or in the last two weeks.

	Medication/supplement Name	**Dosage**	**Route of Admin.**	**Dosing schedule (how often)**	**Taking since when?**	**Reason for taking**	**Has this medication helped with your fatiguing illness?**
Example	**Aspirin**	**81 mg**	**oral**	**1 pill/day**	Jan 2009	**Prevention of cardio-vascular events**	**No (don't know)**
Example	**Vitamin D**	**1000 IU**	**oral**	**1 pill per day**	Sep 2010	**Prevention of osteoporosis**	**Not sure**
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							

	Medication/supplement Name	Dosage	Route of Admin.	Dosing schedule (how often)	Taking since when?	Reason for taking	Has this medication helped with your fatiguing illness?
19							
20							
21							
22							
23							
24							
25							
26							
27							

Examples of dosing
every night at bedtime
twice a day
3x a day
4x a day
every morning
every evening
as needed

Physical Examination Form

Subject ID Number

____

Date ______/______/_______
Month Day Year

Section 2: Physical Examination

STAFF ID:__ __ __

***Subject ID:__ __ __ __ __ __ __ __ __** **DATE: ____/____/____**

Section 1: Vital Measurements		STAFF ID:__ __ __
Supine measurements		
Blood pressure (mmHg)	**Heart Rate**	**Respiratory Rate**
☐☐☐/☐☐☐ Systolic diastolic	☐☐☐ beats/min	☐☐☐ breaths/min
Standing for _ _ minutes		
Blood pressure (mmHg)	**Heart Rate**	**Respiratory Rate**
☐☐☐/☐☐☐ Systolic diastolic	☐☐☐ **beats/min**	☐☐☐ **breaths/min**

Oral Temperature: ☐☐☐.☐°F

Weight: ☐☐☐.☐☐ lbs. **Height:** ☐ ft.☐☐.☐☐ in.

Neck Circumference: ☐☐☐in.

Waist Circumference: ☐☐☐in. **Hip Circumference:** ☐☐☐in.

Section 2: Physical Examination

STAFF ID:__ __ __

Physical examination	Comments If abnormal, explain or describe below
1. Mental Status *Affect* .... Normal 1 ☐ Abnormal 2 ☐ *Speech* .... Normal 1 ☐ Abnormal 2 ☐	
Mental status summary Normal 1 ☐ Abnormal 2 ☐ Exam not done 3 ☐	
2. Oral cavity *Mercury fillings* .... Absent 1 ☐ Present 2 ☐ *Dentition* .... Good 1 ☐ Poor 2 ☐ Edentulous 3 ☐ *Gums* .... Good 1 ☐ Fair 2 ☐ Poor 3 ☐ *Oropharynx* .... Normal 1 ☐ Abnormal 2 ☐	
Oral status summary Normal 1 ☐ Abnormal 2 ☐ Exam not done 3 ☐	
3. Head *Hair* .... Normal 1 ☐ Alopecia 2 ☐ *Scalp* .... Normal 1 ☐ Abnormal 2 ☐	
Head summary Normal 1 ☐ Abnormal 2 ☐ Exam not done 3 ☐	

Section 2: Physical Examination

STAFF ID:__ __ __

Physical examination	Comments If abnormal, explain or describe below
4. Neck	
Supple .... Yes 1 ☐ No 2 ☐	
Thyroid .... Normal 1 ☐ Enlarged 2 ☐	
Masses .... No 1 ☐ Yes 2 ☐	
Jugular venous Distension .... Absent 1 ☐ Present 2 ☐	
Bruit .... 1 ☐ 2 ☐	
Neck summary Normal 1 ☐ Abnormal 2 ☐ Exam not done 3 ☐	
5. Eyes	
Pupils	
Equal .... Yes 1 ☐ No 2 ☐	
Round .... 1 ☐ 2 ☐	
Reactive .... 1 ☐ 2 ☐	
Accommodate .... 1 ☐ 2 ☐	
Sclera .... Normal 1 ☐ Icteric 2 ☐ Other 3 ☐	
Fundoscopic .... Normal 1 ☐ Abnormal 2 ☐	
Photophobia 1 ☐ 2 ☐	
Eyes summary Normal 1 ☐ Abnormal 2 ☐ Exam not done 3 ☐	

Section 2: Physical Examination

STAFF ID:__ __ __

Physical examination	Comments If abnormal, explain or describe below
6. Ears *Tympanic membrane* .... Normal 1 ☐ Abnormal 2 ☐ *Canals* .... Normal 1 ☐ Abnormal 2 ☐	
Ears summary Normal 1 ☐ Abnormal 2 ☐ Exam not done 3 ☐	
7. Nose *Nasal mucosa* .... Normal 1 ☐ Abnormal 2 ☐	
Nose summary Normal 1 ☐ Abnormal 2 ☐ Exam not done 3 ☐	
Pharynx *Mucosa* Normal 1 ☐ Abnormal 2 ☐ *Volume adequate* 1 ☐ 2 ☐ *Tongue large* 1 ☐ 2 ☐ *TMJ tender* 1 ☐ 2 ☐	
Pharynx summary Normal 1 ☐ Abnormal 2 ☐ Exam not done 3 ☐	

Section 2: Physical Examination

STAFF ID:__ __ __

Physical examination	Comments If abnormal, explain or describe below
8. Thyroid No / Yes *Visible*.................................... 1 ☐ 2 ☐ *Palpable* .... 1 ☐ 2 ☐ *Nodules*................................. 1 ☐ 2 ☐ *Size* 1 ☐ 2 ☐	
Thyroid summary Normal 1 ☐ Abnormal 2 ☐ Exam not done 3 ☐	
9. Chest Normal / Abnormal *Shape* .... 1 ☐ 2 ☐	
Chest summary Normal 1 ☐ Abnormal 2 ☐ Exam not done 3 ☐	
10. Heart and large arteries Normal / Abnormal *Heart palpation* .... 1 ☐ 2 ☐ *Heart auscultation (rate, rhythm, murmurs, extra sounds)* ....1 ☐ 2 ☐ Absent / Present *Carotid artery Auscultation/Pain (**systolic bruit**)*........................1 ☐ 2 ☐ *Abdominal artery auscultation (bruit)*................. 1 ☐ 2 ☐	
Heart and large arteries summary Normal 1 ☐ Abnormal 2 ☐ Exam not done 3 ☐	

Section 2: Physical Examination

STAFF ID:__ __ __

Physical examination	**Comments** If abnormal, explain or describe below
11. Lungs Normal / Abnormal *Chest percussion*.................... 1 ☐ 2 ☐ *Lung auscultation* (sound, rales, crepitations) ..... 1 ☐ 2 ☐	
Lungs summary Normal 1 ☐ Abnormal 2 ☐ Exam not done 3 ☐	
12a. Abdomen Normal / Abnormal *Bowel Sounds* .... 1 ☐ 2 ☐ No / Yes *Tenderness* .... 1 ☐ 2 ☐ *Masses*...................................1 ☐ 2 ☐	
Abdomen summary Normal 1 ☐ Abnormal 2 ☐ Exam not done 3 ☐	
12b. Liver No / Yes *Palpable* .... 1 ☐ 2 ☐	*If palpable, describe here*
Liver summary Normal 1 ☐ Abnormal 2 ☐ Exam not done 3 ☐	
12c. Spleen No / Yes *Palpable*............................... 1 ☐ 2 ☐	*If palpable, describe here*
Spleen summary Normal 1 ☐ Abnormal 2 ☐ Exam not done 3 ☐	

Section 2: Physical Examination

STAFF ID:__ __ __

<table>
<tr><th>Physical examination</th><th>Comments
If abnormal, explain or describe below</th></tr>
<tr><td>13. Extremities
No / Yes
Edematous .... 1 ☐ 2 ☐
Dependent rubor 1 ☐ 2 ☐

<table><tr><th>Pulses</th><th>Left</th><th>Right</th></tr><tr><td>Radial</td><td></td><td></td></tr><tr><td>Femoral</td><td></td><td></td></tr><tr><td>Tibial art. or dorsalis pedis artery</td><td></td><td></td></tr></table></td><td></td></tr>
<tr><td>Extremities summary
Normal 1 ☐ Abnormal 2 ☐ Exam not done 3 ☐</td><td></td></tr>
<tr><td>14. Skin
Absent / Present
Jaundice................................1 ☐ 2 ☐
Acne ....1 ☐ 2 ☐
Ulcerations ....1 ☐ 2 ☐
Rash.......................................1 ☐ 2 ☐
Lesions ....1 ☐ 2 ☐
Too dry ....1 ☐ 2 ☐</td><td></td></tr>
<tr><td>Skin summary
Normal 1 ☐ Abnormal 2 ☐ Exam not done 3 ☐</td><td></td></tr>
</table>

Section 2: Physical Examination

STAFF ID:__ __ __

Physical examination	Comments If abnormal, explain or describe below
15. Neurologic *15a. Cerebellar* Normal / Abnormal *Finger-Nose-Finger*.........1 ☐ 2 ☐ *Gait*.................................1 ☐ 2 ☐ *Heel to shin*.....................1 ☐ 2 ☐ *Tandem stance/gait*..........1 ☐ 2 ☐ *with augmentation* 1 ☐ 2 ☐ Negative / Positive *Romberg*...........................1 ☐ 2 ☐ *Handedness* *Right* 1 ☐ *Left* 2 ☐ *Ambi* *3* ☐	
Cerebellar summary Normal 1 ☐ Abnormal 2 ☐ Exam not done 3 ☐	

Section 2: Physical Examination

STAFF ID:__ __ __

Physical examination	Comments If abnormal, explain or describe below
15b. Cranial Nerves Normal / Abnormal *Visual fields (confrontation)*.................1 ☐ 2 ☐ *Shoulder raise*.................1 ☐ 2 ☐ *Hearing (gross)*................1 ☐ 2 ☐ *Extra ocular muscles*........1 ☐ 2 ☐ *Facial expression*............1 ☐ 2 ☐	
Cranial nerves summary Normal 1 ☐ Abnormal 2 ☐ Exam not done 3 ☐	
15c. Sensory (hands, feet) Normal / Abnormal *Light touch*.......................1 ☐ 2 ☐ *Pinprick*...........................1 ☐ 2 ☐ *Vibration*..........................1 ☐ 2 ☐ *Proprioception (great toe, up/down*..........1 ☐ 2 ☐	

Section 2: Physical Examination

STAFF ID:__ __ __

Physical examination	Comments If abnormal, explain or describe below
Sensory (hands, feet) summary Normal 1 ☐ Abnormal 2 ☐ Exam not done 3 ☐	
15d. Muscles Normal / Abnormal *Tone* .... 1 ☐ 2 ☐ *Atrophy* 1 ☐ 2 ☐ *Rise from chair to tip toes*.............................1 ☐ 2 ☐ Absent / Present *Involuntary movements*....1 ☐ 2 ☐ *Proximal muscle strength* Normal 1 ☐ Abnormal 2 ☐ *Distal muscle strength* Normal 1 ☐ Abnormal 2 ☐	
Muscle strength summary Normal 1 ☐ Abnormal 2 ☐ Exam not done 3 ☐	
15e. Reflexes Normal / Abnormal / Hyper *Biceps*..................1 ☐ 2 ☐ 3 ☐ *Triceps* ....1 ☐ 2 ☐ 3 ☐ *Patellar* ....1 ☐ 2 ☐ 3 ☐ *Ankle Jerk*............1 ☐ 2 ☐ 3 ☐ Absent / Present *Babinski* .... 1 ☐ 2 ☐	
Reflexes summary Normal 1 ☐ Abnormal 2 ☐ Exam not done 3 ☐	

Section 2: Physical Examination

STAFF ID:__ __ __

Physical examination	Comments If abnormal, explain or describe below
Neurologic summary Normal 1 ☐ Abnormal 2 ☐ Exam not done 3 ☐	
16. Lymph Nodes *Cervical* — Normal / Enlarged / Tender *Posterior* ....1 ☐ 2 ☐ 3 ☐ *Anterior*...............1 ☐ 2 ☐ 3 ☐ *Supraclavicular*.........1 ☐ 2 ☐ 3 ☐ *Axillary*......................1 ☐ 2 ☐ 3 ☐ *Inguinal*.....................1 ☐ 2 ☐ 3 ☐	*Note if supraclavicular fullness present.*
Lymph nodes summary Normal 1 ☐ Abnormal 2 ☐ Exam not done 3 ☐	
17. Joints Muscles (review swelling, heat or redness, nodularity, ROM, extensiblity, tender points) Normal / Abnormal *Spine*..................................... 1 ☐ 2 ☐ *Shoulders*.............................. 1 ☐ 2 ☐ *Elbows*................................. 1 ☐ 2 ☐ *Wrists*.................................... 1 ☐ 2 ☐ *Hands*.................................... 1 ☐ 2 ☐ *Hips*...................................... 1 ☐ 2 ☐ *Knees*.................................... 1 ☐ 2 ☐ *Ankles*.................................. 1 ☐ 2 ☐ *Feet*....................................... 1 ☐ 2 ☐	
Joints and muscles summary Normal 1 ☐ Abnormal 2 ☐ Exam not done 3 ☐	

Section 2: Physical Examination

STAFF ID:__ __ __

Physical examination	**Comments** If abnormal, explain or describe below
18. Other (specify) Mental status Normal Abnormal 1 ☐ 2 ☐ *Speech* 1 ☐ 2 ☐ *Orientation* 1 ☐ 2 ☐	
19. Other (specify)	
20. Other (specify)	
21. Other (specify)	

Section 4: Clinical Impressions/ Differential Diagnoses

Impression: Overall impression of this patient
[*Mental status, physical condition, over - or underweight, age corresponding to calendar or not, systems with problems, etc. If you find anything abnormal -what differential diagnoses would you pursue should this be your (not a study) patient]*

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PATIENT ASSESSMENT

NAME:______________________________________ DATE: ___________________

VITAL SIGNS

OBJECTIVE
Eyes: Anisocoria? Pupillary response (reactive to light, accommodation)? Photophobia?
ENT: Non-exudative pharyngitis? Pharynx ample? Large tongue? TMJ tender?
Neck: Thyromegaly? Carotidynia? Full range of motion? Cervical lordosis?
Lymph nodes: Tender and/or swollen cervical or axillary nodes? Supraclavicular fullness.
Heart:
Lungs:
Abdomen: RUQ tender? Hepatosplenomegaly?
Extremities: Edema? Dependent rubor?
Skin: Acne rosacea? Livido reticularis?

MUSCULOSKELETAL
Good tone? Atrophy?
Joint swelling, heat, or redness? Nodularity?
Range of motion normal ? Hyperextensibility?
Tenderpoints of fibromyalgia present?
Myofascial bands present?

NEUROLOGICAL
Handedness: ( ) Right ( ) Left ( ) Ambi
Cranial nerves:
Finger-to-nose: Tremor? Dysmetria?
Random alternating movements: Dysdiadokinesia? Psychomotor slowing?
Balance: Can patient balance on non-dominant foot for 5 seconds?
Tandem stance: Does patient titubate or topple with augmentation (spell WORLD backward)?
Romberg: Does patient titubate or topple? Arm drift?
DTRs:

Babinski reflexes (optional)
Tinel's and/or Phelan's sign (optional)
Adson's sign (optional)
Neurocognitive (optional Serial 7 Subtraction, Digit Span)

MENTAL STATUS (all optional)
Affect: (Normal? Anxious? Flat?)
Speech: (Normal? Halting? Rapid?)
Fund of knowledge: (Average? Above or below average?)
Oriented to person, place, and time:
Reality check: (Any hallucinations or delusions?)
Cyclothymia: (Alternating depression/mania? Risky behaviors? Grandiosity?
Decreased need for sleep? Racing thoughts? Pressured speech?}

Centers for Disease Control Symptom Inventory

The full questionnaire for the CDC Symptom Inventory and scoring are available at
http://www.cdc.gov/cfs/pdf/wichita-data-access/symptom-inventory.pdf and
http://www.cdc.gov/cfs/pdf/wichita-data-access/si-scoring-algorithm.pdf