

## Lyme Disease & Health Screening Questionnaire

Mass Functional Medicine

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**NAME:**

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**Score the occurrence of each symptom on the following scale: circle 1 if mild, circle 2 if moderate, circle 3 if severe**

**(Circle only the numbers that are printed)**

1	Are you complaining of fatigue?	O Yes	O No	1	2	3
2	Is your fatigue on and off ?	O Yes	O No			
3	Is your fatigue random ? (without a known reason)	O Yes	O No			
4	Is it always improved by food?	O Yes	O No			
5	Is it aggravated by food?	O Yes	O No			
6	Does your fatigue persist for days after exertion?	O Yes	O No			
7	Is it worse at school or at work or at home?	O Yes	O No			
8	Does it prevent you from working ?	O Yes	O No			
9	Can you be exhausted despite eating and sleeping well?	O Yes	O No			
10	Does it happen that you may feel well enough one day, but not the next?	O Yes	O No			
11	<b>Do you sometimes have headaches?</b>	O Yes	O No	1	2	3
12	Are they like a tight helmet, pressure?	O Yes	O No			
13	Are they associated with light sensitivity?	O Yes	O No			
14	Are they associated with neck pain or stiffness?	O Yes	O No			
15	Are they random? (without a known reason)	O Yes	O No			
16	Are they caused or aggravated by reading ?	O Yes	O No			
17	Do they happen at any time?	O Yes	O No			
18	Are they worse by certain food ?	O Yes	O No			
19	Are they worse at school or at work or at home?	O Yes	O No			
20	<b>Do you sometimes feel on your skin abnormal feelings?</b>	O Yes	O No	1	2	3
21	<b>Numbness?</b>	O Yes	O No			
22	<b>Pins and needles, or burning or crawling insect sensations?</b>	O Yes	O No			
23	<b>Stabbing pain or shooting pain?</b>	O Yes	O No			
24	Is it at different locations of your body at different times? (migratory)	O Yes	O No			
25	Is it random ? (without a known reason)	O Yes	O No			
26	Is it worse at work, at school or at home?	O Yes	O No			
27	<b>Do you have muscle weakness?</b>	O Yes	O No			
28	To the point of dropping objects?	O Yes	O No			
29	To the point of having difficulty getting up?	O Yes	O No			
30	Is your muscular weakness on and off ?	O Yes	O No			
31	Is it improved by rest ?	O Yes	O No			
32	<b>Did you have facial paralysis? Bell's palsy?</b>	O Yes	O No	1	2	3
33	<b>Have you ever had a facial numbness?</b>	O Yes	O No			
34	<b>Have you ever had a facial pain?</b>	O Yes	O No			
35	<b>Do you sometimes have blurred vision?</b>	O Yes	O No	1	2	3
36	<b>Do you sometimes have double vision?</b>	O Yes	O No			

37	<b>Do you sometimes have cloudy vision?</b>	O Yes	O No				
38	<b>Do you have eye pain when moving your eyes?</b>	O Yes	O No				
39	Is it on and off ?	O Yes	O No				
40	Is it random ? (without a known reason)	O Yes	O No				
41	Is it worse at work, at school or at home?	O Yes	O No				
42	<b>Do you have hearing impairment?</b>	O Yes	O No				
43	<b>Buzzing, ring , ear pain</b>	O Yes	O No	1	2	3	
44	Is it on and off ?	O Yes	O No				
45	Is it worse at work or at school or at home?	O Yes	O No				
46	<b>Do tou have a hypersensitivity to light?</b>	O Yes	O No				
47	<b>Do tou have a hypersensitivity to noise?</b>	O Yes	O No				
48	<b>Do tou have a hypersensitivity to touch?</b>	O Yes	O No				
49	<b>Do tou have a hypersensitivity to smell?</b>	O Yes	O No				
50	<b>Do you sometimes have involuntary movements?</b>	O Yes	O No				
	if yes, did it start from one week to the next?	O Yes	O No				
	if yes, did it start within 10 days from any infection?	O Yes	O No				
51	Do you sometimes have tics?	O Yes	O No				
52	<b>Do you sometimes have twitching?</b>	O Yes	O No	1	2	3	
53	<b>Do you have tremors?</b>	O Yes	O No	1	2	3	
54	<b>Do you sometimes have any dizziness?</b>	O Yes	O No				
55	<b>Lightheadedness, poor balance, difficulty walking?</b>	O Yes	O No	1	2	3	
56	<b>Does noise provoke dizziness ?</b>	O Yes	O No				
57	Is it worse at work, at school or at home?	O Yes	O No				
58	<b>Do you sometimes have brain fog (does it take more time to understand)?</b>	O Yes	O No	1	2	3	
59	<b>Do you sometimes have difficulty finding your words?</b>	O Yes	O No				
60	<b>Do you sometimes have difficulty learning?</b>	O Yes	O No				
61	<b>Do you sometimes have difficulty focusing or reading?</b>	O Yes	O No	1	2	3	
62	<b>Do you sometimes have difficulty remembering why you went to a room?</b>	O Yes	O No				
63	<b>Do you have difficulty remembering a shopping list or names?</b>	O Yes	O No				
64	<b>Do you sometimes have difficulty remembering what you heard 10 minutes ago?</b>	O Yes	O No	1	2	3	
65	<b>Do you sometimes have difficulty finding your way, do you get lost, or go to the wrong place?</b>	O Yes	O No	1	2	3	
66	<b>Do you have a decline in performances at school or at work even in not noticeable by others?</b>	O Yes	O No				
67	Is it on and off ?	O Yes	O No				
68	Is it random ? (without a known reason)	O Yes	O No				
69	Is it worse at work or at school or at home?	O Yes	O No				
70	<b>Difficulty with speech or writing</b>	O Yes	O No	1	2	3	
71	<b>Do you have mood swings, irritability or depression</b>	O Yes	O No	1	2	3	
72	<b>OCD?</b>	O Yes	O No				
	if yes, did it start from one week to the next?	O Yes	O No				
	if yes, did it start within 10 days from any infection?	O Yes	O No				
73	<b>Have you ever have a loss of appetite, not eating?</b>	O Yes	O No				
74	<b>Generalized anxiety?</b>	O Yes	O No				
	if yes, did it start from one week to the next?	O Yes	O No				
	if yes, did it start within 10 days from any infection?	O Yes	O No				
75	<b>New onset of separation anxiety? (question for children)</b>	O Yes	O No				
76	<b>Panic attack ?</b>	O Yes	O No				
	if yes do the panic last for at least 30 minutes?	O Yes	O No				
77	<b>Developmental regression ? (question for children)</b>	O Yes	O No				
78	<b>Are you sometimes depressed ?</b>	O Yes	O No				
	if yes are you more emotional numb than sad?	O Yes	O No				

	If yes is it on and off without a known reason?	O Yes	O No				
79	<b>Do you have sometimes intrusive thoughts?</b> (thoughts that scare you)	O Yes	O No				
80	<b>Did you become more irritable ?</b>	O Yes	O No				
81	<b>Oppositional disorder?</b> (question for children)	O Yes	O No				
82	<b>Do you have a behavioral change?</b>	O Yes	O No				
	if yes, did it start from one week to the next?	O Yes	O No				
	if yes, did it start within 10 days from any infection?	O Yes	O No				
83	<b>Do you sometimes have or did you have a personality change?</b>	O Yes	O No				
	if yes, did it start from one week to the next?	O Yes	O No				
	if yes, did it start within 10 days from any infection?	O Yes	O No				
84	<b>Suicidal ideation ?</b>	O Yes	O No				
85	<b>Hypervigilance?</b>	O Yes	O No				
86	<b>Do people and objects around you may seem unreal?</b>	O Yes	O No				
87	<b>Do you avoid social interaction at school or at work?</b>	O Yes	O No				
88	<b>Did you lose interest in school and school activities?</b>	O Yes	O No				
89	Was any mood disorder ever improved by Motrin, Advil or by antibiotics?	O Yes	O No				
89	Is your mood disorder on and off?	O Yes	O No				
90	Does it happen randomly? (without a known reason)	O Yes	O No				
91	Is it worse at work or at school or at home?	O Yes	O No				
92	<b>Have you ever had unexplained seizures ?</b>	O Yes	O No				
93	<b>Do you have muscular or cramps?</b>	O Yes	O No	1	2	3	
94	Is it on and off ?	O Yes	O No				
95	Is it random ? (without a known reason)	O Yes	O No				
96	Is it worse at work or at school or at home?	O Yes	O No				
97	<b>Back pain ?</b>	O Yes	O No				
98	<b>Do you have joint pain affecting multiple joints at different times ?</b>	O Yes	O No				
99	Is it on and off ?	O Yes	O No				
100	Is it random ? (without a known reason)	O Yes	O No				
101	Is it worse at work or at school or at home?	O Yes	O No				
102	<b>Joint swelling ?</b>	O Yes	O No				
103	<b>Stiffness of the neck or back?</b>	O Yes	O No	1	2	3	
104	if yes does it last more than 30 minutes?	O Yes	O No				
105	if yes, is it in the morning?	O Yes	O No				
106	<b>Neck crack or neck stiffness?</b>	O Yes	O No	1	2	3	
107	<b>Intense pain in the middle of your back spreading to the extremities?</b>	O Yes	O No				
108	<b>Do you sometimes have joint pain?</b>	O Yes	O yes	1	2	3	
	shoulder	O Yes	O No				
	Elbow	O Yes	O No				
	Wrist	O Yes	O No				
	Fingers	O Yes	O No				
	Hip	O Yes	O No				
	Knee	O Yes	O No				
	Ankle	O Yes	O No				
	toes	O Yes	O No				
109	Is it triggered only by motion or exertion?	O Yes	O No				
110	Is it worse at work or at school or at home?	O Yes	O No				
111	Improved by antibiotics?	O Yes	O No				
112	<b>Bone pain (deep limb pain) ?</b>	O Yes	O No				
113	<b>Do you feel your heart beating irregularly , fast or slow ?</b>	O Yes	O No	1	2	3	
114	<b>Do you have a history of heart murmur or valve prolapse?</b>	O Yes	O No	1	2	3	
115	<b>upset stomach?</b>	O Yes	O No	1	2	3	
116	<b>Do you have recurrent unexplained abdominal pain?</b>	O Yes	O No				
117	<b>Change in bowel fuction (constipation or diahrea)?</b>	O Yes	O No	1	2	3	

118	Do you sometimes get bloated seconds after eating?	O Yes	O No				
119	Do you have food sensitivity?	O Yes	O No				
120	unexplained breast milk production; breast pain	O Yes	O No	1	2	3	
121	Iritable bladder or bladder dysfunction	O Yes	O No	1	2	3	
122	Sexual dysfunction or loss of libido?	O Yes	O No	1	2	3	
123	Does the sun cause you to have blisters or skin lesions?	O Yes	O No				
124	Do you sometimes have red or red-brown urine ?	O Yes	O No				
125	Do you have a shortness of breath or cough ?	O Yes	O No	1	2	3	
126	Do you sometimes have air hunger ?	O Yes	O No				
127	Do you sometimes have chest pain or rib cage pain?	O Yes	O No	1	2	3	
128	Bedwetting or loss of daytime bladder control after being dry?	O Yes	O No				
129	Do you have menstrual irregularities?	O Yes	O No	1	2	3	
130	Do you have or did you have any vaginal or urethral discharge or urinary pain?	O Yes	O No				
131	Excessive thirst ?	O Yes	O No				
132	Do you sometimes have Itching or hives ?	O Yes	O No				
133	Unexplained fevers, sweats, chills, or flushing ?	O Yes	O No	1	2	3	
134	Unexplained recurrent fever ?	O Yes	O No				
135	Swollen glands	O Yes	O No	1	2	3	
136	Do you sometimes have wheezings ?	O Yes	O No				
137	New onset of intolerance to alcohol ?	O Yes	O No	1	2	3	
138	Sore throat?	O Yes	O No	1	2	3	
139	testicular or pelvic pain?	O Yes	O No	1	2	3	
140	New onset of motion sickness or vertigo ?	O Yes	O No	1	2	3	
141	Do you have dental amalgam?	O Yes	O No				
141	Chemical exposure?	O Yes	O No				
142	Known mold exposure ?	O Yes	O No				
143	History of water damage ?	O Yes	O No				
144	Lived in an underground basement or do you have an underground basement?	O Yes	O No				
145	Have you ever had a tic bite?	O Yes	O No				
146	Have you ever had a tic bite followed by bull's eye rash?	O Yes	O No				
147	Have you ever had a tic bite followed by a flulike syndrome?	O Yes	O No				
148	Unexpexted weight loss or gain	O Yes	O No	1	2	3	
149	Unexpected hair loss	O Yes	O No	1	2	3	
150	Did Antibiotics, taken for other reasons, improve you?	O Yes	O No				
151	Did Antihistamine, taken for whatever reason, improve you?	O Yes	O No				
152	Disturbed sleep; too much, or too little, or early awakening	O Yes	O No	1	2	3	
153	Daytime sleepiness?	O Yes	O No				
HAVE YOU EVER BEEN DIAGNOSED WITH....							
154	Diabetes ?	O Yes	O No				
155	Adrenal fatigue ?	O Yes	O No				
156	Thyroid disorder?	O Yes	O No				
157	Low testosterone ?	O Yes	O No				
158	Auto-immune disease?	O Yes	O No				
159	Celiac disease ?	O Yes	O No				
160	Asthma ?	O Yes	O No				
161	Seasonal allergy ?	O Yes	O No				
162	Fibromyalgia ?	O Yes	O No				
163	Chronic fatigue syndrome ?	O Yes	O No				
164	Gout ?	O Yes	O No				
165	Kidney stone ?	O Yes	O No				

166	Lyme disease ?	O Yes	O No				
167	Bartonella?	O Yes	O No				
168	Babesia?	O Yes	O No				
169	TMJ ?	O Yes	O No				
	<b>DO YOU HAVE A FAMILY HISTORY OF...</b>						
170	Lyme disease or tick borne disease?	O Yes	O No				
171	Kidney stone?	O Yes	O No				
172	Allergy?	O Yes	O No				
172	Psychatric disorder?	O Yes	O No				
173	if does this family member live under the same roof?	O Yes	O No				
174	<b>DO YOU HAVE ANY ALLERGY TO SUPPLEMENT OR MEDICATION?</b>	O Yes	O No				
175	Are you menopausal?	O Yes	O No				
176	have you ever gotten a MRI or CT scan?	O Yes	O No				<b>Result:</b>
177	have you ever seen a neurologist?	O Yes	O No				<b>Diagnosis:</b>
178	have you ever seen a rheumatologist?	O Yes	O No				<b>Diagnosis:</b>
179	have you ever an ophthalmologist?	O Yes	O No				<b>Diagnosis:</b>
180	have you ever seen a psychiatrist?	O Yes	O No				<b>Diagnosis:</b>
181	have you ever seen another specialist physician?	O Yes	O No				<b>Diagnosis:</b>
<b>Add up all numbers you have circled</b>		<b>TOTAL SECTION 1:</b>					
<b>If you scored a 3 for each of the following in section 1, give yourself 5 additional points:</b>							
	Fatigue						
	Forgetfulness, poor term memory						
	Joint pain or swelling						
	Tingling, numbnness, burning or stabbing sensations						
	Disturbed sleep: too much, too little, early awakening						
						<b>TOTAL SECTION 2:</b>	
<b>Check the box for each statement you can agree with</b>							
	You have had a tick bite with no rash or flulike symtoms	O Yes	O No				if yes add 3 points
	You have had a tick bite , a bull's eye rash or an undefinedd rash, followed by flulike symptoms	O Yes	O No				If yes add 5 points
	You live in what is considered a Lyme-endemic area	O Yes	O No				if yes add 2 points
	You have a family member who has been diagnosed with Lyme and/or other tick-borne infections	O Yes	O No				If yes add 1 point
	You experience mugratory muscle pain	O Yes	O No				If yes add 4 points
	You experience migratory joint pain	O Yes	O No				If yes add 4 points
	You experience tingling/numbness that migrates and /or comes and goes	O Yes	O No				If yes add 4 points
	You have received a prior diagnosis of chronic fatigue syndrome or fibromyalgia	O Yes	O No				If yes add 3 points
	You have received a prior diagnosis of a specific autoimmune disorder						
	(Lupus, MS, or rheumatoid arthritis or of a nonspecific autoimmune disorder.)	O Yes	O No				If yes add 3 points
	You have had positive Lyme test (IFA, ELISA, Western Blot, PCR and/or Borrelia culture)	O Yes	O No				If yes add 5 points
						<b>TOTAL SECTION 3:</b>	
<b>Thinking about your overall physical health, for how many of the past thirty days was your physical health not good?</b>							
			if 0-5 days				add 1 point
			if 6-12 days				add 2 points
			if 13-20 days				add 3 points
			if 21-30 days				add 4 points
						<b>TOTAL SECTION 4:</b>	
<b>Thinking about your overall mental health, for how many of the past thirty days was your mental health not good?</b>							
			if 0-5 days				add 1 point
			if 6-12 days				add 2 points

		if 13-20 days	add 3 points		
		if 21-30 days	add 4 points		
<b>TOTAL SECTION 5:</b>					
Questionnaire revised and updated, from the original Horowitz questionnaire by Richard I. Horowitz, M.D. 2014					
<b>If you score is 46 or above you are very likely to have Lyme disease</b>					
<b>If you score is less than 46 you may still have Lyme disease, interpretation of symptoms is necessary to evaluate the likelihood of Lyme disease</b>					