

Fluoroquinolone Toxicity and Potential Mitochondrial Impairment

Medical Evaluation Preparation Form

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original version November, 2012

Name: _____ Birth date: _____ Today's date: _____

Please mark checkboxes for symptoms you have experienced since starting FQs. (you may check more than one box)

Mark the left column if you Currently Have a Symptom
Mark the middle column if you Had Symptoms but Recovered
Also, Mark the right column if you had a New Onset of Symptom More Than 21 Days After Stopping the Drug (optional)

- Musculoskeletal:**
- | | | | |
|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tendon pain [technically: Tendinopathy] |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tendon rupture |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Joint pain [Arthralgia] |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Popping/cracking joints |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Muscle pain [Myalgia/Myositis] |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Muscle weakness |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Muscle wasting [Atrophy] |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Back pain (circle location: low back, mid back, high back) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Inability to perform with endurance or duration expected of age group and background [Exercise intolerance] |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Loss of padding in palms or bottoms of feet |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bone spur |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Vertebrae hematoma/degeneration/damage |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Spinal disc bulging/degeneration/herniated/thinning |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Joint Hypermobility due to muscle weakness and atrophy |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diaphragm weakness |

Other: _____

- Peripheral Nervous System:**
- | | | | |
|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tingling, prickling, pins & needles, or numbness, bugs running on skin, water trickling in arms or legs |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Buzzing, in arms or legs |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pressure or squeezing feelings in arms or legs |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Feelings of electrical zaps, shocks, or deep stabs in arms or legs |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Burning pain in arms or legs (this can also be tendinopathy, but mark here anyway) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pain with normal non-painful touch or hypersensitivity to pain [Allodynia, Hyperalgesia] |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nerve pain of any kind (shocks, tingling, numbness, buzzing, pressure, etc.), in teeth, mouth, and lips |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Facial nerve pain of any kind [like trigeminal neuralgia] |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Head pressure, or squeezing feelings, on the head |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Muscle twitching of small pieces of independent muscle [Fasciculations] |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Muscle twitching of the whole muscle body [Tremors] |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Neuralgia (pain along nerve trunk lines; skip if not familiar) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Guillan-Barré Syndrome |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Increased or reduced sensitivity of the skin to pain, temperature and touch |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Limb Weakness |

Other: _____

- Dermatological**
- | | | | |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Itching [Pruritus] |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dry skin and dry patches |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hair loss on scalp, eyebrows, eyelashes [Alopecia] |

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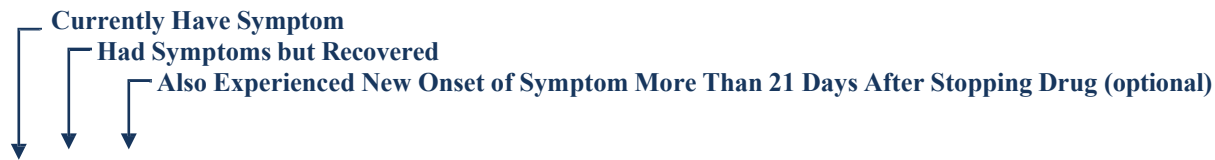
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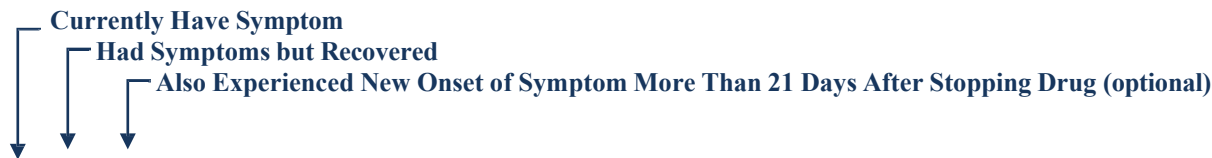
Gastrointestinal:

- | | | | |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Difficulty swallowing [Dysphagia] |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Abdominal pain |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Vomiting |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Persistent softer stool lasting more than 2 weeks |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Persistent diarrhea lasting more than 2 weeks |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Persistent constipation lasting more than 2 weeks |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Delayed gastric emptying [Gastroparesis] |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nausea / feeling of fullness |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Acid reflux lasting more than 2 weeks |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bloating, gas, flatulence, or abdominal distension |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Undigested food in stool or fatty stool or floating stool [suggests Maldigestion] |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Persistent rash on tongue or in mouth [suggests oral Candidiasis, Psoriasis, etc.] |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Food sensitivities / intolerance |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Complication with healing after surgery (Anastomosis Insufficiency) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Rectal spasms |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heartburn (Dyspepsia) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Inflammation of mouth (Stomatitis) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chronic gallbladder inflammation (pain under right rib)/ dysfunction / polyps / sludge/stone |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Medication or supplement intolerance |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Malnutrition |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Weight control issues |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Abnormal stool smell |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Colon polyps |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | H Pylori |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cholestatic Jaundice |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pancreatic inflammation (Pancreatitis) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Increase in liver values Bilirubin, ALT/AST, GGT, AP, LDH |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Enlargement of the liver (Hepatomegaly) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Non-alcoholic fatty liver disease (NAFLD) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cysts of the pancreas and liver |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Gastro-intestinal inflammation |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Blood in stool with mucous |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pseudomembranous colitis |

Other: _____

Vision:

- | | | | |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eye focusing problems |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dry eyes [Xerophthalmia] |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Light sensitivity [Photophobia] |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Floaters or black specks |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Visual acuity decrease [Scotoma, etc.] |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Double vision [Diplopia] |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Retinal tears |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Color blindness |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Drooping eyelids (Ptosis) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Inability to process all visual input |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Seeing halos |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Partial vision loss |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eye muscle and ligament weakness |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eye movement disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eye flashes (Photopsia) – probable PVD |



- ☐ ☐ ☐ Retinal detachment (sudden appearance of dark dots, spots, floaters, or flashes of light)
- ☐ ☐ ☐ Visual snow (migraine snowing or persistent visual migraine aura without pain)

Other: _____

Ear Nose Throat:

- ☐ ☐ ☐ Ringing in ears [Tinnitus]
- ☐ ☐ ☐ Dizziness or vertigo and/or loss of sense of balance [No Equilibrioception]
- ☐ ☐ ☐ Hearing sensitivity to low noises increased [Hyperacusis]
- ☐ ☐ ☐ Hearing loss or disorder
- ☐ ☐ ☐ Ear wax reduced or replaced by dry grit
- ☐ ☐ ☐ Dry mouth [Xerostomia]
- ☐ ☐ ☐ Taste perversions [Dysgeusia]
- ☐ ☐ ☐ Smell hypersensitivity to odors [Hyperosmia]
- ☐ ☐ ☐ Smell things not there [Phantosmia]
- ☐ ☐ ☐ Atrophy of the cartilages and bones of the middle ear
- ☐ ☐ ☐ Dry nose
- ☐ ☐ ☐ Painful blistering in ear or mouth
- ☐ ☐ ☐ Inflammation of oral mucosa
- ☐ ☐ ☐ Mouth polyps (Papilloma)
- ☐ ☐ ☐ Hoarseness
- ☐ ☐ ☐ Difficulty speaking and producing vocal sounds [Dysphonia]
- ☐ ☐ ☐ Pressure in ears
- ☐ ☐ ☐ Pharynx

Other: _____

Cardiovascular:

- ☐ ☐ ☐ Abnormal heart rhythm [heart palpitations] / Arrhythmia
- ☐ ☐ ☐ Poor peripheral vascular circulation (cold feet/hands)
- ☐ ☐ ☐ Swelling limbs [peripheral edema]
- ☐ ☐ ☐ Purple or red spots under skin esp. in limbs [Purpura, Petechiae]
- ☐ ☐ ☐ Easy and/or excessively large bruising
- ☐ ☐ ☐ Swollen veins
- ☐ ☐ ☐ Sudden change in hand color, with severe coldness and numbness lasting a few minutes [Raynaud's]
- ☐ ☐ ☐ High blood pressure [hypertension] or Low blood pressure [hypotension]
- ☐ ☐ ☐ Stroke
- ☐ ☐ ☐ Prolonged QT interval
- ☐ ☐ ☐ Ventricular tachycardia (Torsade de pointes)
- ☐ ☐ ☐ Cardiac arrest
- ☐ ☐ ☐ Fast heart beat (Tachycardia)
- ☐ ☐ ☐ Slow heart beat (Bradycardia)
- ☐ ☐ ☐ Poor peripheral vascular circulation (cold feet/hands)
- ☐ ☐ ☐ Shortness of breath
- ☐ ☐ ☐ Aortic dissection
- ☐ ☐ ☐ Aortic aneurysm
- ☐ ☐ ☐ Inflammation of the blood vessels (vasculitis) / leukocytoclastic vasculitis

Other: _____

☐ **Currently Have Symptom**
☐ **Had Symptoms but Recovered**
☐ **Also Experienced New Onset of Symptom More Than 21 Days After Stopping Drug (optional)**

Autonomic Nervous System:

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lightheadedness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Change in sweating response, not enough when hot [Anhidrosis], or inappropriately much [Hyperhidrosis]
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sweating /lock or excessive perspiration
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness when getting up / Feeling of impending unconsciousness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dilatation of blood vessels (vasodilation) / low blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dysautonomia

Other: _____

Endocrine:

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feeling consistently cold
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Unexplained weight change
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	New thyroid abnormalities (Hyperthyroidism or Hypothyroidism)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia (Diabetes)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hormone imbalance
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid nodules
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Salt cravings
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hyperglycemia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pituitary atrophy

Other: _____

Urinary:

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst and urination [Polydipsia and Polyuria]
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Purple, brown, red, or frothy urine
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent urinary tract infection
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood and crystal in urine
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fungal and bacterial infection
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Renal failure
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Necrotizing renal vasculitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fluid retention
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Interstitial cystitis (PBS, IC)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Increase of creatinine
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Interstitial nephritis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney crystals (Crystalluria)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urgent urination, urination control
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Incomplete bladder emptying
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Post micturition incontinence

Other: _____

Reproductive:

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of libido
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of nighttime and/or morning erections [Male Hypogonadism]
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reduced ejaculate [Hypospermia]
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Testicular pain [Orchialgia]
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ovarian cysts
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry vagina during intercourse
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Missing menstruation 3 months or more [Amenorrhoea]
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Elevated PSA (men)

Currently Have Symptom

Had Symptoms but Recovered

Also Experienced New Onset of Symptom More Than 21 Days After Stopping Drug (optional)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Penile Tissue Changes (narrowing, shrinkage, wrinkled)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Early menopause
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful blistering of penis or vagina
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heavier/longer menstrual bleeding
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Penis fracture
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low sperm count
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain during ejaculation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prostate irritation / inflammation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Miscarriage

Dental:

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Softer oral gum tissue or abnormal bleeding gums
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Broken teeth
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TMJ
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Teeth, mouth, and lip nerve pain, of any kind (shocks, tingling, buzzing, etc.)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Many new cavities/ (Periodontitis)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Periodontal disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bone loss

Respiratory:

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Decreased level of SpO2 – Oxygen level
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intense cough with expectoration of large amounts of phlegm
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bronchospasms
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Problems with breathing
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep apnea
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	COPD

General:

- ☐ ☐ ☐ Extreme fatigue
- ☐ ☐ ☐ Multiple Chemical Sensitivity (MCS)
- ☐ ☐ ☐ Candida
- ☐ ☐ ☐ Skeletal / muscle tissue breakdown (Rhabdomyolysis)
- ☐ ☐ ☐ Anaphylactic reaction

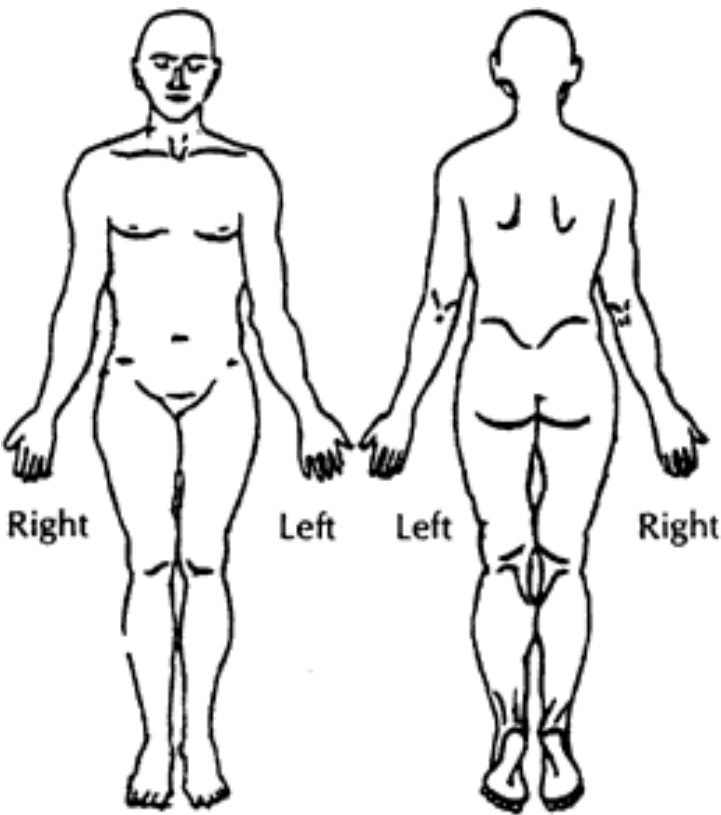
Other: _____

Describe patterns of recovery and timeframes:

Additional notes on symptoms:

In the chart at right, please mark areas where you experience:

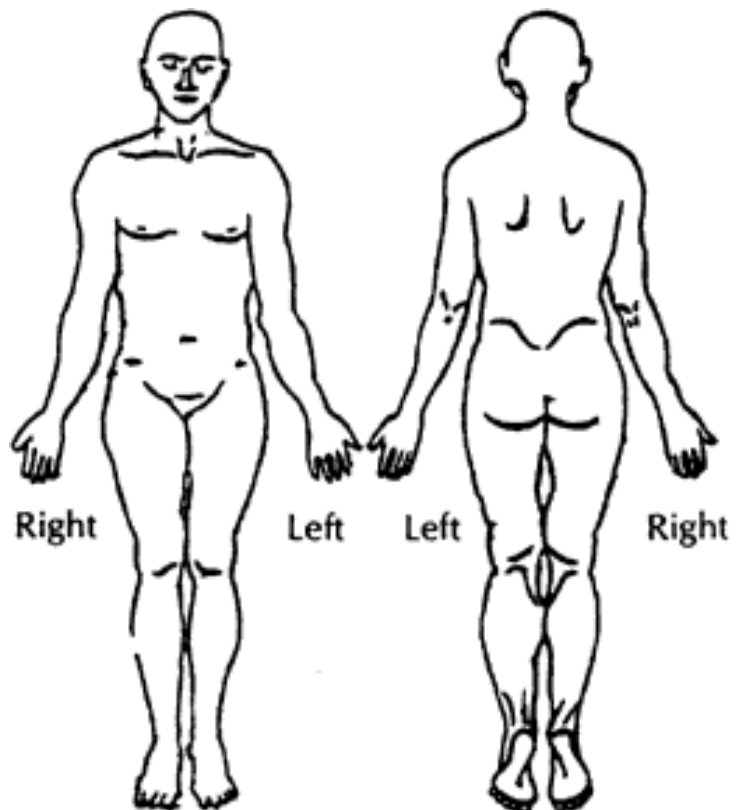
- Burning [Mark as “B”]



In the chart at right, please mark areas where you experience:

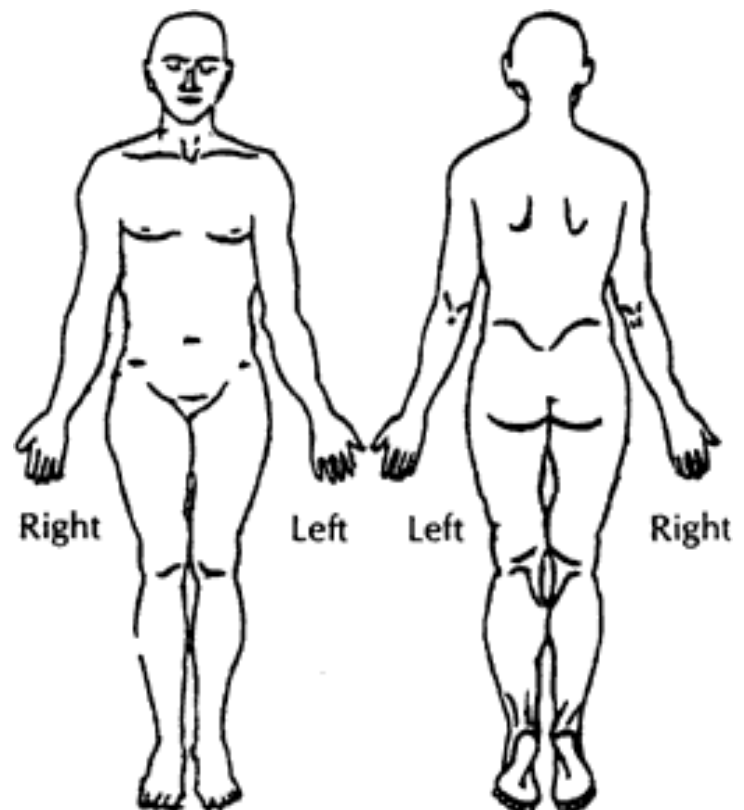
- Tingling, prickling, pins & needles [Mark as “T”]
- Numbness [Mark as “N”]
- Bugs running on skin, moving fabric, water running down [Mark as “S”]
- Buzzing [Mark as “Z”]
- Pressure or squeezing feelings [Mark as “P”]
- Feelings of electrical zaps or shocks [Mark as “E”]
- Feelings of moving waves [Mark as “W”]

Do not include “burning” sensations in this chart. You may use colors instead of letters if it is easier for you.



In the chart at right, please mark areas where you experience:

- Aches, dull or sharp [Mark as “A”]
- Tightness [Mark as “T”]
- Pain at the time of muscle exertion [Mark as “P”]
- Weakness [Mark as “W”]



What drugs and supplements are you currently taking?

NAME (e.g., cyclobenzaprine)	DOSE PER USE (e.g., 5 mg)	HOW OFTEN? (e.g., 1 daily)	REASON FOR USE (e.g., muscle tightness)

What are your 3 worst symptoms today, where are they, and how long have each been that way?

1.
2.
3.

Doctors recently seen and test results: (include date, name, specialty, findings)

Reason for seeing doctor today and questions I have for this doctor:

OPTIONAL TRIGGER INFORMATION FOR INTEGRATIVE/ALTERNATIVE PRACTITIONER VISITS

(Strictly western medical doctors aren't always interested in these)

Mark, if Have Experienced

▼ **Allergy/Sensitivity/Intolerance /Food Sensitivities:** (in the empty space, you may indicate how it affects you and for how long)

- ☐ Caffeine
- ☐ Sugar
- ☐ Alcohol
- ☐ MSG
- ☐ Soy
- ☐ Gluten
- ☐ Dairy
- ☐ Processed food/natural flavors
- ☐ Nightshades (potatoes, tomatoes, eggplant, (for some) peppers)
- ☐ Acidic foods (e.g., vinegar, tomatoes, lemon juice, lime juice)
- ☐ Sulfites
- ☐ Aspartame
- ☐ Carbonated beverages (non-alcoholic)
- ☐ Medication intolerance
- ☐ Supplement intolerance
- ☐ Cleaning products
- ☐ Fume intolerance
- ☐ Chemical intolerance
- ☐ Materials sensitivity

Other: _____

Specific Animal Product Exacerbation Triggers: (it is understood these are usually not consistently repeatable)

- ☐ Beef (non-organic)
- ☐ Poultry (non-organic)
- ☐ Fish (non-shellfish) (farmed)
- ☐ Shellfish (shrimp (farmed), scallops, crab, lobster, clams)
- ☐ Pork (non-organic)
- ☐ Lamb (non-organic)
- ☐ Other red meat (non-organic)

Other: _____

Exacerbation of FQD Triggers: (in the empty space, you may indicate how it affects you and for how long)

- ☐ Stress
- ☐ Lack of sleep
- ☐ Exercise beyond personal physical limitations
- ☐ Weather related storms and temperature changes
- ☐ Anxiety
- ☐ Illness
- ☐ Seasons (especially heat, cold)
- ☐ Electrical sensitivity (e.g., to MRI procedure)
- ☐ Ovulation
- ☐ Secretory/Luteal menstrual phase (between ovulation and menstruation)
- ☐ Impending menstruation
- ☐ High altitude
- ☐ Exposure to fumes or touch of chemicals
- ☐ Atmospheric pressure
- ☐ Alcohol
- ☐ Drugs (recreational)
- ☐ Viruses
- ☐ Radiation: IMF Injury CT scan MRI, X-ray
- ☐ UV Pools with chlorinated water or with lots of minerals

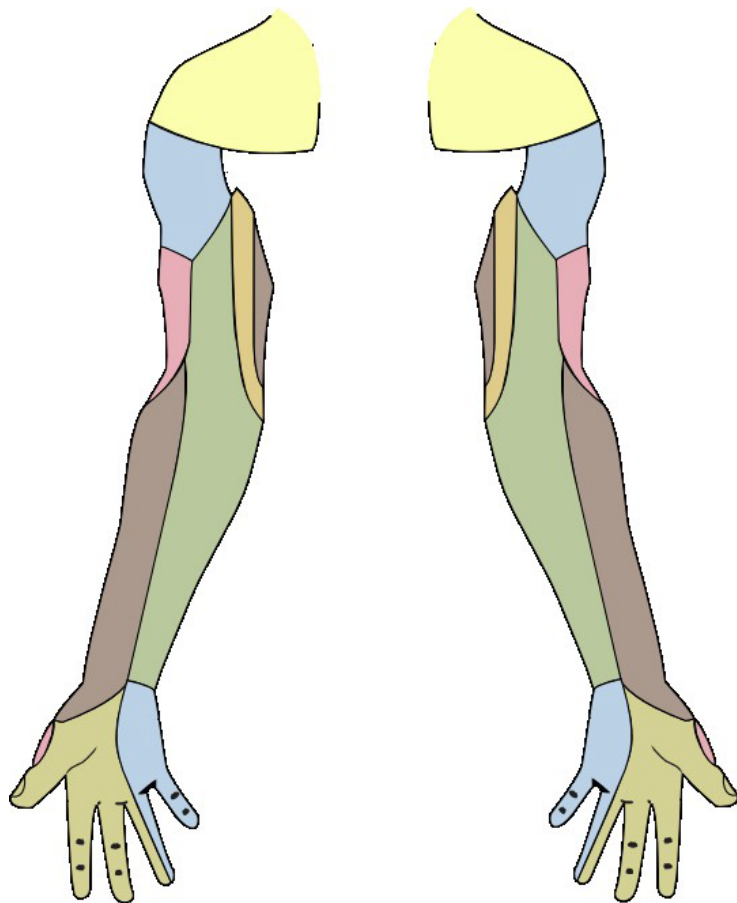
OPTIONAL DIAGRAMS FOR NEUROLOGIST VISITS

In the chart below, please mark areas where you experience:

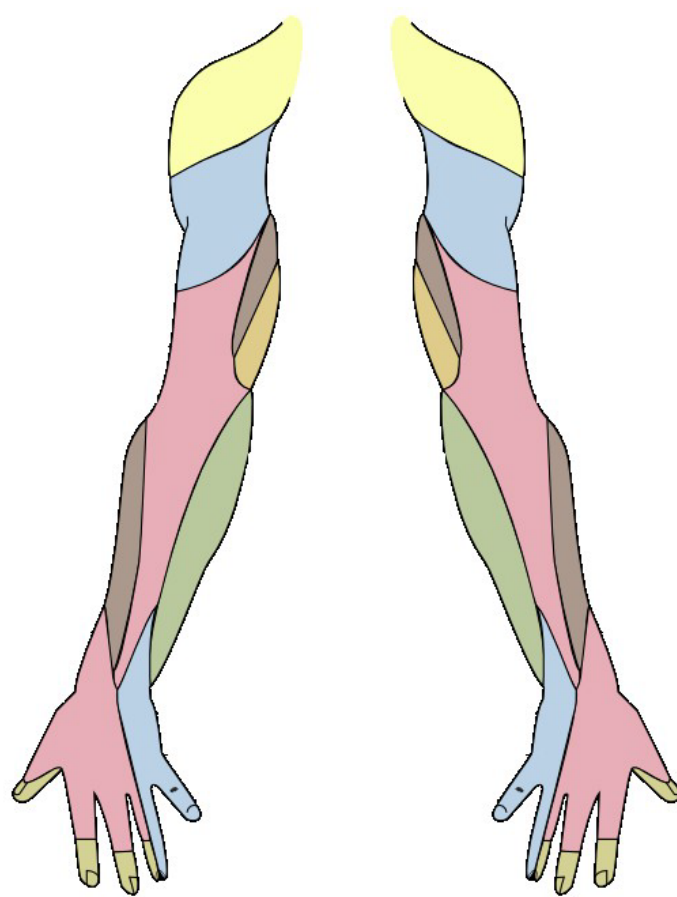
- Tingling, prickling, pins & needles [Mark as “T”]
- Numbness [Mark as “N”]
- Bugs running on skin, moving fabric, water running down [Mark as “S”]
- Buzzing [Mark as “Z”]
- Pressure or squeezing feelings [Mark as “P”]
- Feelings of electrical zaps or shocks [Mark as “E”]
- Feelings of moving waves [Mark as “W”]

Do not include “burning” sensations in this chart.

Front of Arms and Palms



Back of Arms and Back of Hands

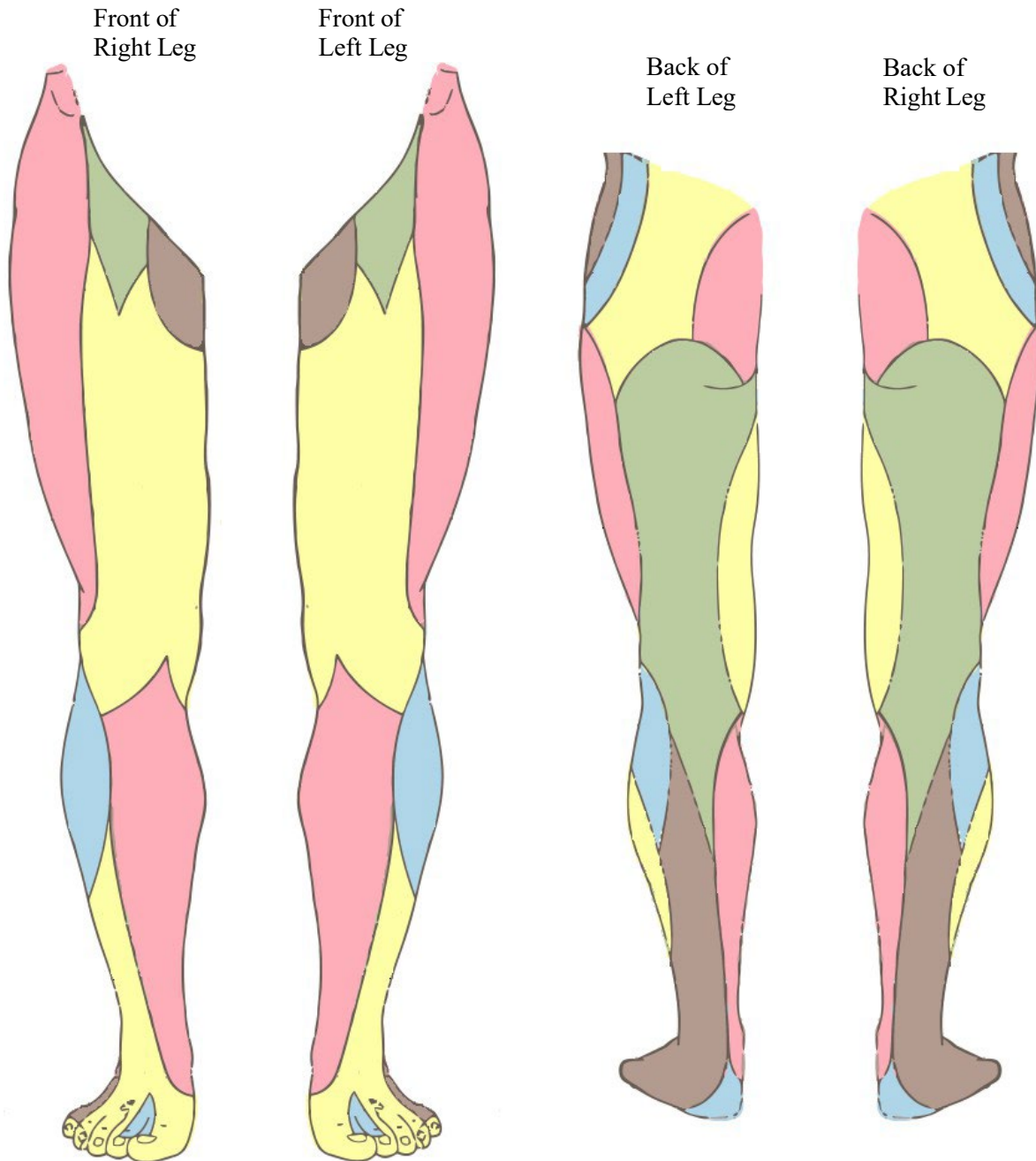


OPTIONAL DIAGRAMS FOR NEUROLOGIST VISITS

In the chart below, please mark areas where you experience:

- Tingling, prickling, pins & needles [Mark as “T”]
- Numbness [Mark as “N”]
- Bugs running on skin, moving fabric, water running down [Mark as “S”]
- Buzzing [Mark as “Z”]
- Pressure or squeezing feelings [Mark as “P”]
- Feelings of electrical zaps or shocks [Mark as “E”]
- Feelings of moving waves [Mark as “W”]

Do not include “burning” sensations in this chart.



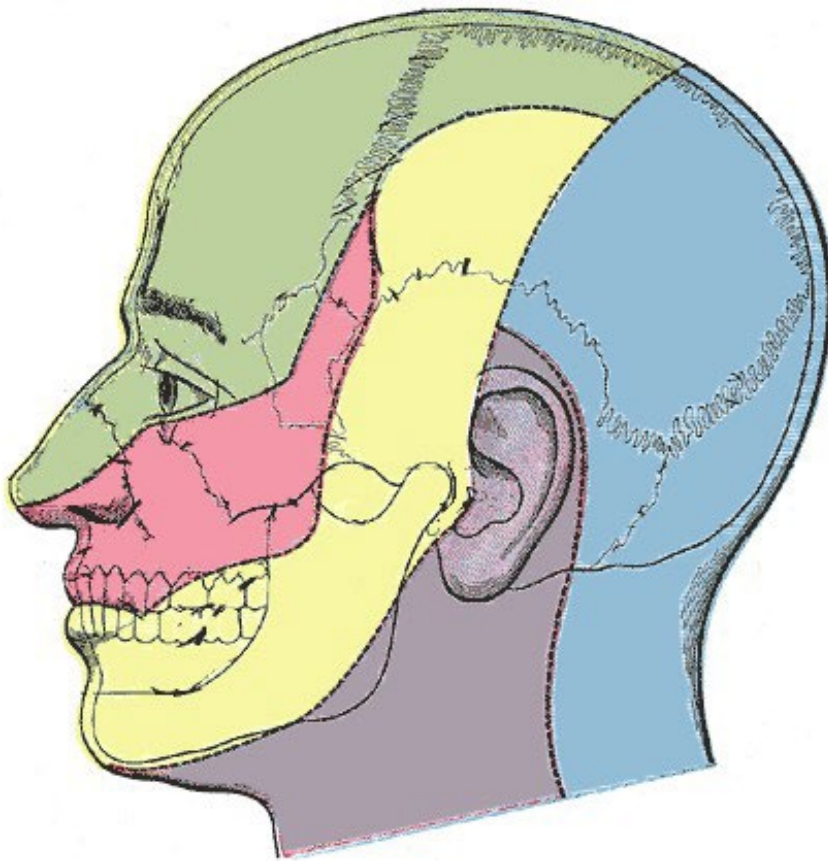
OPTIONAL DIAGRAMS FOR NEUROLOGIST VISITS

Please mark areas where you experience:

- Tingling, prickling, pins & needles [Mark as “T”]
- Numbness [Mark as “N”]
- Bugs running on skin, moving fabric, water running down [Mark as “S”]
- Buzzing [Mark as “Z”]
- Pressure or squeezing feelings [Mark as “P”]
- Feelings of electrical zaps or shocks [Mark as “E”]
- Feelings of moving waves [Mark as “W”]

For this chart also include:

- Burning sensations [Mark as “B”]



Disclaimer: This form is for informational purposes only

This form was created by the Fluoroquinolone Toxicity Study Foundation in collaboration with Bruce Miller, based on many years of communication with patients and extensive surveys conducted among individuals affected by fluoroquinolone toxicity. It is intended for informational and preparatory purposes only and does not constitute medical advice, diagnosis, or treatment. The form is designed to support patients in documenting and communicating their symptoms more clearly to healthcare professionals. Always consult a licensed medical provider for any health concerns or before making decisions related to treatment or diagnosis.