



Tick-Borne Disease Patient Symptom Checklist

Complete the checklist below based on your current symptoms. Bring the completed checklist to your next appointment for discussion with your physician.

History of tick bite? Yes No If so, when:

Symptoms	Severity	Frequency
Skin issues If yes, select all that apply:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant <input type="radio"/> Spotted rash over large area <input type="radio"/> EM rash in a discrete circle <input type="radio"/> Linear red streaks
Swollen glands	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant
Sore throat	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant
Fever	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant
Joint pain If yes, select all that apply:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant <input type="radio"/> Fingers/Toes <input type="radio"/> Ankles/Wrists <input type="radio"/> Knees/Elbows <input type="radio"/> Hips/Shoulders
Joint swelling If yes, select all that apply:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant <input type="radio"/> Fingers/Toes <input type="radio"/> Ankles/Wrists <input type="radio"/> Knees/Elbows <input type="radio"/> Hips/Shoulders
Muscle complaints If yes, select all that apply:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant <input type="radio"/> Pain <input type="radio"/> Cramps <input type="radio"/> Stiffness <input type="radio"/> Weakness <input type="radio"/> Twitching
Cognitive difficulties If yes, select all that apply:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant <input type="radio"/> Thinking <input type="radio"/> Concentrating <input type="radio"/> Forgetfulness <input type="radio"/> Speech errors
Mood difficulties If yes, select all that apply:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant <input type="radio"/> Mood swings <input type="radio"/> Irritability <input type="radio"/> Depression <input type="radio"/> Anxiety <input type="radio"/> Panic Attacks
Psychosis If yes, select all that apply:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant <input type="radio"/> Hallucinations <input type="radio"/> Delusions <input type="radio"/> Paranoia <input type="radio"/> Bipolar
Neurological issues If yes, select all that apply:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant <input type="radio"/> Tremors <input type="radio"/> Seizures <input type="radio"/> Headaches <input type="radio"/> Dizziness <input type="radio"/> Off balance <input type="radio"/> Light headed
Eye/vision difficulties If yes, select all that apply:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant <input type="radio"/> Sensitivity to light <input type="radio"/> Double vision <input type="radio"/> Blurry vision <input type="radio"/> Floaters
Ear/hearing difficulties If yes, select all that apply:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant <input type="radio"/> Sensitivity to sound <input type="radio"/> Ear pain <input type="radio"/> Buzzing <input type="radio"/> Ringing <input type="radio"/> Decreased hearing

Over for more symptom



Tick-Borne Disease Patient Symptom Checklist

~ Continued ~

Symptoms	Severity	Frequency
Nerve issues If yes, select all that apply:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant
	<input type="radio"/> Tingling <input type="radio"/> Numbness <input type="radio"/> Burning <input type="radio"/> Stabbing <input type="radio"/> Shooting pain	
Facial paralysis/Bells Palsy	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant
Dental pain	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant
Neck pain/stiffness	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant
Fatigue, poor stamina	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant
Sleep difficulties If yes, select all that apply:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant
	<input type="radio"/> Insomnia <input type="radio"/> Broken sleep <input type="radio"/> Early waking <input type="radio"/> Excessive sleeping	
Unexplained weight gain or loss	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant
Unexplained hair loss	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant
Pain in genital area	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant
Menstrual irregularities	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant
Unusual milk production or breast pain	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant
Irritable bladder/dysfunction	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant
Erectile dysfunction or loss of sex drive	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant
Digestive difficulties If yes, select all that apply:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant
	<input type="radio"/> Nausea <input type="radio"/> Heartburn <input type="radio"/> Stomach Pain <input type="radio"/> Constipation <input type="radio"/> Diarrhea <input type="radio"/> Cramping	
Cardiac Issues If yes, select all that apply:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant
	<input type="radio"/> Heart murmur <input type="radio"/> Valve prolapse <input type="radio"/> Palpitations or skips <input type="radio"/> "Heart Block" on EKG	
Chest issues If yes, select all that apply:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant
	<input type="radio"/> Chest wall pain <input type="radio"/> Sore ribs <input type="radio"/> Breathlessness <input type="radio"/> Chronic Cough	
Head congestion	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant
Night sweats	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant

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 (609) 512-1468  [PRINCETONIH.COM](https://www.princetonih.com)  INFO@PRINCETONIH.COM

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