



JACK ZOLDAN, M.D., LTD

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CHRONIC FATIGUE SYNDROME QUESTIONS

Please PRINT your answers and describe them to the best of your ability.

1. Describe your limitations _____

2. What does your fatigue prevent you from doing? _____
3. How long have you been fatigued? _____
4. How many days a week are you fatigued? _____
5. How many hours a day are you fatigued? _____
6. Do you wake up in the morning feeling fatigued? Yes No
7. Have you ever done anything or taken anything that gave you relief from the fatigue, albeit temporarily?

8. Do you have chronic Pain? Yes No
Where? _____
Is the pain in your joints or muscles?
How often and for how long do you get pain? _____
Is there swelling associated with the pain? Yes No
9. Does anxiety or stress make your symptoms worse? Yes No
10. Have you ever noticed that any foods seem to worsen your problem? Yes No
Which foods? _____
Do you avoid these foods? Yes No
How do these foods affect you? _____

11. Do you experience symptoms that might be termed "brain fog?" Yes No
Do you have problems with memory? Yes No



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Do you have concentration problems? Yes No

Thinking problems? Yes No

12 Do you get headaches? Yes No

If yes, please describe the following:

- nature _____
- location _____
- frequency _____
- severity _____
- timing _____
- any associated symptoms. _____

13. Do you get palpitations? Yes No

How often and how long do they last? _____

Is there anything you can do to bring on or worsen them? _____

14. Do you have psychological symptoms? Yes No

(Please check all that apply and describe)

- irritability _____
 - mood swings _____
 - panic attacks _____
 - anxiety _____
 - depression _____
 - other psychological problem _____
- _____

15. Do you have any of the following problems? (Please check all that apply and describe.)

- Sore Throat _____



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Enlarged and possibly painful lymph nodes in the neck and/or armpits _____

Unexplained muscle pain. _____

Joint pain that can move from joint to joint without any signs or swelling

Sleep that is not refreshing and waking up as tired or more tired than when you went to bed

Headaches that are of new patterns and severity. Please describe these _____

Exhaustion that lasts more than 24 hours after physical exercise or a stressful experience

Pain in the abdominal region. Please describe this _____

Allergies or other sensitivities to any of the following:
 food _____
 alcohol _____
 odors _____
 medications _____
 noise _____
 chemicals _____

Chest pains _____

Abdominal bloating _____

Diarrhea _____



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Chronic cough _____

Dry mouth _____

Being dizzy when standing up from a seated position

Problems with balance _____

Fainting _____

Irregular heartbeat or palpitations _____

Ear aches Left ear Right ear Both ears _____

Joint stiffness in the morning _____

Nausea _____

Night sweats _____

Chills _____

Shortness of breath? What causes this? _____

Problems with your sight?

blurring

eye pain Left eye Right eye Both eyes

sensitivity to light _____

dry eyes _____

Weight gain? How much over what period? _____

Weight loss? How much over what period? _____