

Lyme Follow-Up

Name: _____

Age: _____

Date: ____/____/____

COMPARED TO YOUR LAST VISIT, please rate your symptoms using the scale below.

A Little Better
 Much Better
 A Little Worse
 Much Worse
 No Change
 New

Symptoms	Change?		Notes
Fevers			
Sweats			
Chills			
Flushing			
Fatigue, poor stamina			
Unexplained hair loss			
Swollen glands			
Sore throat			
Testicular pain			
Pelvic pain			
Unexplained menstrual irregularity			
Breast pain			
Bladder irritability/dysfunction			
Sexual dysfunction / loss of libido			
Nausea			
Constipation			
Diarrhea			
Chest pain			
Rib soreness			
Shortness of breath			
Cough			
Heart palpitations, pulse skips			
Neck stiffness / back stiffness			
Neck cracks			
Neck pain			
Joint stiffness			
Joint pain			
Muscle pain			
Muscle cramps			
Twitching of muscles			
Headache			

Symptoms	Change?		Notes
Numbness / tingling			
Facial paralysis			
Blurry vision			
Floater			
Light sensitivity			
Ear buzzing/ringing			
Ear pain			
Sound sensitivity			
Poor balance			
Lightheadedness / woozy			
Tremor			
Confusion			
Difficulty thinking			
Forgetfulness			
Poor short-term memory			
Disorientation, getting Lost			
Difficulty with speech			
Word-finding problems			
Reversing numbers or letters			
Difficulty writing			
Mood swings			
Depression/anxiety			
Sleep disturbance			

Worst Symptoms: