Living Well Partnership

v1

Patient Name: _____

Date of birth: _____

Date today: _____

Chronic Fatigue Syndrome – Patient questionnaire			
Have you experienced any of the following symptoms;	YES	NO	Specify duration and write down more details if applicable;
Fatigue/tiredness for at least 6 weeks	◯	◯	e.g. Persistent (>4months), recurrent, new onset
Prolonged worsening of your symptoms following minor exertion	◯	◯	
Sleeping disturbances	◯	◯	
Muscle or multiple joint pain	◯	◯	
Headache	◯	◯	
Painful lymph nodes (Lumps or bumps)	◯	◯	
Sore throat	◯	◯	
Short term memory problems, brain fog, confusion, inability to concentrate	◯	◯	
Flu-like symptoms	◯	◯	
Dizziness/Nausea	◯	◯	
Heart racing/palpitations	◯	◯	
Breathing stops repeatedly while sleeping	◯	◯	
New or worsening weakness/paralysis, loss of sensation in one limb, speech disturbances or vision problems	◯	◯	
Unintentional weight loss	◯	◯	
Unexplained enlargement of lymph nodes	◯	◯	
Persistent fever, night sweats	◯	◯	
Recent worsening of existing chronic diseases	◯	◯	
Abnormal bleeding	◯	◯	
Shortness of breath, worsening cough	◯	◯	

Please return this form to Living Well Partnership by emailing it to soccg.livingwell.partnership@nhs.net or drop off at reception