

Questionnaire on Lyme-Like Illness

Patient ID code: _____

For over 15 years, researchers in the Murdoch University School of Veterinary and Life Sciences have been investigating tick-borne pathogens. This particular survey is about Lyme-like symptoms and will be linked to the specimen that you give us; it should take around 15 minutes to complete. I agree that by submitting this survey I give my consent for the results to be used in research. I understand that the findings of this study may be published and that no information that can specifically identify me will be published. I understand that all information being collected will be treated as confidential and will not be released to a third party unless required to do so by law. I know that I may change my mind, withdraw my consent, and stop participating at any time simply by not completing the survey.

I wish to proceed with the survey Yes No

First, we would like to know a little about you. Please mark the box most appropriate to you. All information is anonymous and confidential. **We do not need to know who you are!**

a. What is your age? _____ years

b. Your sex Male Female

c. What state do you live in?

- | | |
|---|--|
| <input type="checkbox"/> Australian Capital Territory | <input type="checkbox"/> South Australia |
| <input type="checkbox"/> New South Wales | <input type="checkbox"/> Tasmania |
| <input type="checkbox"/> Northern Territory | <input type="checkbox"/> Victoria |
| <input type="checkbox"/> Queensland | <input type="checkbox"/> Western Australia |

Now please circle the appropriate response to the following questions:

1. Have you ever previously had a tick bite overseas that you are aware of? YES/NO
2. Have you ever previously had a tick bite in Australia that you are aware of? YES/NO

If no go to question 11

3. If you have been bitten by a tick, did you develop any clinical symptoms? YES/NO
4. Was the tick species identified? YES/NO
5. When did the tick bite occur? _____
6. Did you have a rash at the site of the tick bite? YES/NO
7. Did you have a rash at other sites on the body subsequent to the bite? YES/NO. If so, where?

8. Did you have flu-like symptoms subsequent to the bite? YES/NO
9. If you were bitten in Australia, which State or Territory were you in when this occurred?

10. If you were bitten outside Australia, which country were you in?

11. Do you have a family member who has been diagnosed with a Lyme disease-like illness and/or other tick-borne infections? YES/NO
12. If yes, please list the diagnosis/diagnoses _____
13. Have you received a prior diagnosis of chronic fatigue syndrome? YES/NO
14. Have you received a prior diagnosis of fibromyalgia? YES/NO
15. Have you have received a prior diagnosis of a specific autoimmune disorder (lupus or SLE, multiple sclerosis or MS, or rheumatoid arthritis)? YES/NO. If so, which one?

16. Have you ever had your Rheumatoid Factor tested? YES/NO. If yes, what was the level?

17. Have you have received a prior diagnosis of a non-specific autoimmune disorder? YES/NO
18. Have you have received a prior diagnosis of Parkinson's disease? YES/NO
19. Have you have had a positive *Borrelia burgdorferi* sensu lato disease test (IFA, ELISA, Western blot, PCR, and/or *Borrelia* culture)? YES/NO. If yes, what type of test and in which laboratory was it conducted? _____

20. Have you had a positive result for any Lyme co-infections? YES/NO. If yes, please state what testing was done and which co-infections were identified?

21. Are you currently taking any medication (including herbal medications)? YES/NO

If so please list: _____

22. We are now interested in whether you are experiencing any of the following symptoms either at the moment or intermittently. Please circle yes or no for the following and, if yes, please place a score after each symptom; 1= Mild, 2= Moderate and 3 =Severe

1. Unexplained fevers, sweats, chills, or flushing? YES/NO ____

2. Unexplained weight change; loss or gain? YES/NO ____

3. Fatigue or tiredness? YES/NO ____

If so, how long for? _____

4. Unexplained hair loss? YES/NO ____

5. Swollen glands? YES/NO ____

6. Flu-like symptoms such as a sore throat? YES/NO ____

7. Flu-like symptoms such as a runny nose? ____

8. Testicular or pelvic pain? YES/NO ____

9. Unexplained menstrual irregularity? YES/NO ____

10. Unexplained breast milk production or breast pain? YES/NO ____

11. Irritable bladder or bladder dysfunction? YES/NO ____

12. Nausea? YES/NO ____

13. Changes in bowel function YES/NO ____

If so, was it constipation or diarrhea? (please circle).

14. Chest pain or rib soreness? YES/NO ____

15. Shortness of breath or cough? YES/NO ____

16. Heart palpitations, pulse skips or an abnormal heart rhythm where the heart beats too slowly (bradycardia)? YES/NO ____

a. If so, did you feel light-headed or likely to collapse? YES/NO ____

17. Have you had a history of a heart murmur or valve prolapse? YES/NO ____

18. Pain or swelling in your joints that can come and go as well as move around the body?
YES/NO ____

19. Stiffness of the neck or back? YES/NO ____

