Fibromyalgia Canadian Multisystem Questionnaire

Adapted from the Canadian Fibromyalgia Consensus Document, B.M. Carruthers & M. van De Sande, et al, 2005

PATIENT'S NAME: _____ **DATE:** _____

Patient Questionnaire: Fibromyalgia Syndrome

Symptoms and Signs Checklist (symptoms vary in type and intensity)

Please answer YES or NO to each question AND then rate how strongly you experience the symptoms by circling a number on a scale of 1 to 5

1=rarely 2=sometimes 3=50% of the time 4=most of the time 5=all the time

1.	Musculoskeletal Systems							
A	Generalised stiffness	NO	YES	1	2	3	4	5
B	Muscle cramps (e.g. legs)	NO	YES	1	2	3	4	5
C	Chest pressure and pain	NO	YES	1	2	3	4	5
D	Temporomandibular Joint (TMJ) pain (jaw)	NO	YES	1	2	3	4	5
How long have you had these symptoms? ___ mths or years (circle)				Was the onset: ☐ sudden ☐ gradual				

2.	Nervous System							
A	Persistent fatigue	NO	YES	1	2	3	4	5
B	Lack of endurance	NO	YES	1	2	3	4	5
C	Migraines or new onset headaches	NO	YES	1	2	3	4	5
How long have you had these symptoms? ___ mths or years (circle)				Was the onset: ☐ sudden ☐ gradual				

3.	Sensory							
A	Hypersensitivity to pain	NO	YES	1	2	3	4	5
B	Hyper responsiveness to noxious stimuli	NO	YES	1	2	3	4	5
C	Perceptual and dimensional distortions	NO	YES	1	2	3	4	5
D	Feeling of burning or swelling	NO	YES	1	2	3	4	5
E	Sensory overload phenomena	NO	YES	1	2	3	4	5
F	Loss of cognitive map (inability to make use of selective spatial information e.g. environmental landmarks)	NO	YES	1	2	3	4	5
G	Dyspnoea (shortness of breath)	NO	YES	1	2	3	4	5
How long have you had these symptoms? ___ mths or years (circle)				Was the onset: ☐ sudden ☐ gradual				

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4.	Cognitive (mental action or process)							
A	Difficulties processing information	NO	YES	1	2	3	4	5
B	Slowness in cognitive processing	NO	YES	1	2	3	4	5
C	Concentration problems	NO	YES	1	2	3	4	5
D	Difficulties with word retrieval	NO	YES	1	2	3	4	5
E	Confusion and word mix ups	NO	YES	1	2	3	4	5
F	Short-term memory difficulties	NO	YES	1	2	3	4	5
How long have you had these symptoms? ___ mths or years (circle)				Was the onset: ☐ sudden ☐ gradual				

5.	Motor & Balance							
A	Muscle weakness and paralysis	NO	YES	1	2	3	4	5
B	Poor balance, ataxia (loss of full control of bodily movements)	NO	YES	1	2	3	4	5
C	Clumsiness and tendency to drop things	NO	YES	1	2	3	4	5
D	Difficulty in tandem gait (toes of the back foot touch heel of the front foot each step)	NO	YES	1	2	3	4	5
E	Unexplained numbness or tingling	NO	YES	1	2	3	4	5
How long have you had these symptoms? ___ mths or years (circle)				Was the onset: ☐ sudden ☐ gradual				

6.	Neuroendocrine System (Nerve/nervous system & hormone producing glands)							
A	Marked weight change	NO	YES	1	2	3	4	5
B	Heat/cold intolerances	NO	YES	1	2	3	4	5
C	Neuropsychological (observations on the brain and nervous system)	NO	YES	1	2	3	4	5
D	Mood swings, anxiety	NO	YES	1	2	3	4	5
E	Reactive depression (experience fatigue, depressed mood, anxious mood, pain, insomnia)	NO	YES	1	2	3	4	5
How long have you had these symptoms? ___ mths or years (circle)				Was the onset: ☐ sudden ☐ gradual				

7.	Visual & Auditory Disturbances							
A	Visual changes or eye pain	NO	YES	1	2	3	4	5
B	Double, blurred or wavy vision	NO	YES	1	2	3	4	5
C	Dry or itchy eyes	NO	YES	1	2	3	4	5
D	Photophobia (extreme sensitivity to light)	NO	YES	1	2	3	4	5
E	Tinnitus, buzzing or ringing in the ears	NO	YES	1	2	3	4	5
F	Hyperacusis and interference from background noise	NO	YES	1	2	3	4	5
How long have you had these symptoms? ___ mths or years (circle)				Was the onset: ☐ sudden ☐ gradual				

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8.	Sleep Disturbances							
A	Sleep disorder, hyper and insomnia	NO	YES	1	2	3	4	5
B	Non-refreshing sleep	NO	YES	1	2	3	4	5
How long have you had these symptoms? ___ mths or years (circle)				Was the onset: ☐ sudden ☐ gradual				

9.	Circulatory System							
A	Neurally mediated hypotension (Low blood pressure from faulty brain signals)	NO	YES	1	2	3	4	5
B	Fainting or vertigo	NO	YES	1	2	3	4	5
C	Heart palpitations and tachycardia (high resting heart rate)	NO	YES	1	2	3	4	5
D	Fluid retention	NO	YES	1	2	3	4	5
E	Bruising	NO	YES	1	2	3	4	5
How long have you had these symptoms? ___ mths or years (circle)				Was the onset: ☐ sudden ☐ gradual				

10.	Digestive System							
A	Lump in throat	NO	YES	1	2	3	4	5
B	Nausea	NO	YES	1	2	3	4	5
C	Heart burn	NO	YES	1	2	3	4	5
D	Abdominal pain	NO	YES	1	2	3	4	5
E	Constipation and/or diarrhea or an Irritable Bowel Syndrome (IBS) diagnosis	NO	YES	1	2	3	4	5
How long have you had these symptoms? ___ mths or years (circle)				Was the onset: ☐ sudden ☐ gradual				

11.	Urinary System							
A	Irritable/overactive bladder, trouble urinating	NO	YES	1	2	3	4	5
How long have you had these symptoms? ___ mths or years (circle)				Was the onset: ☐ sudden ☐ gradual				

12.	Reproductive System							
A	Dysmenorrhea (painful menstruation)	NO	YES	1	2	3	4	5
B	Pre-Menstrual Syndrome (PMS)	NO	YES	1	2	3	4	5
C	Irregular menstrual cycles	NO	YES	1	2	3	4	5
D	Loss of sexual libido or impotence	NO	YES	1	2	3	4	5
E	Anorgasmia (persistent inability to achieve orgasm despite responding to sexual stimulation)	NO	YES	1	2	3	4	5
How long have you had these symptoms? ___ mths or years (circle)				Was the onset: ☐ sudden ☐ gradual				

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13.	Any Other Symptoms (not covered above)					
A		1	2	3	4	5
B		1	2	3	4	5
C		1	2	3	4	5
D		1	2	3	4	5
E		1	2	3	4	5
How long have you had these symptoms? ___ mths or years (circle)		Was the onset: ☐ sudden ☐ gradual				

14.	Fibromyalgia Syndrome Symptom Onset & Diagnosis			
1	When was the first onset of symptoms that you can remember?		Month/Year:	
2	Was the onset sudden _____ or gradual _____?			
3	Were your symptoms triggered by a particular event?	NO	YES	☐ Infection ☐ Surgery ☐ Physical trauma ☐ Emotional trauma ☐ Other:
4	Have you been formally diagnosed with Fibromyalgia?	NO	YES	☐ General Practitioner ☐ Rheumatologist ☐ Neurologist ☐ Other: Mth/Year:

Staff to complete:

NOTES:

ASSESSMENT CARRIED OUT BY: _____

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