

# PETROVIC CFIDS HEALTH CENTRE

**Date**

**Contact Details**

Name.....  
Title.....  
Street Address.....  
Address (cont).....  
Town/City.....  
State/Province/County.....  
Zip/Postal Code.....  
Work Phone.....  
Home Phone.....  
Fax.....  
Email.....  
Date of Birth.....  
Marital Status.....

**Do you have children?**

**Do your children / partner exhibit similar symptoms?**

**What is your profession?**

**What are your hobbies / physical activities? (Past and present):**

**Medical History (i.e. illnesses, operations, etc.):?**

**Have you been diagnosed with CFIDS/CFS/ME before?  
If you did, by whom?**

**Please give details of your:**

Height  
Weight

**Give details of any medications (past and present)**

**Allergies or sensitivities (to any supplements as well):**

**Current eating habits, favourite foods, food 'cravings'**

**Please state who referred you/recommended Dr Petrovic's CFIDS Programme Protocol:**

Have you ever been tested for the following	Tick for yes	Result:
Coxsackie		
Epstein-Barr (EBV)		
Cytomegallo		
HHV-6		
Other Viruses		
Lyme disease		
Tick Byte Fever (Riketsia)		
Chlamydia		
Primary tuberculosis		

**Please tick the symptoms that apply to you.**

**Tick (for yes) followed by frequency and then intensity (On a scale of 0-5, 5 being the worst) of the specific symptom**

Symptom	Tick for yes - (Leave blank for no)	Frequency / Other information (specified by symptom)	Intensity on a scale of 0-5, 5 being the worst
Headaches			
Pressure in the head (brain fog feeling )			
Cognitive function problems			
Memory lapses			
Concentration difficulties			
Numeric calculation problems			
Co-ordination difficulties			
Speech difficulties			
Blackouts			
Depression			
Anxiety			
Panic attacks			
Mood swings			
Visual disturbances			
Earaches			
Sore throat			
Stiff neck			
Tense shoulders			
Heart palpitations			
Unusual chest pressure			
Digestive problems ( constipation / diarrhoea )			
Numbness or tingling in muscles			
Joint pain			
Muscle aching			

Muscle Weakness			
Cramps ( where?)			
Backache (where?)			
Fatigue that has persisted for at least six months, with the exclusion of all other possible medical reasons and conditions			
Waking up tired in the morning			
Going to bed exhausted, much earlier than usual			
Dizziness			
Nausea			
Impaired sexual life			
Severe PMS			
Frequent canker sores (Mouth Ulcers)			
Cold or flu symptoms (sneezing, sniffing, post nasal drip.)			
Enlarged lymph glands			
Low-grade fevers			
Hot flushes			
Night sweating			
Mild or bad insomnia			
Nightmares (unusual & frequent)			
Problems with driving, esp. at night			
Weight changes			
Hair problems (what?)			
Skin problems (what?)			
Blue complexion, esp. on legs			
Carpal tunnel syndrome (wrist pain)			

Please return this form to Dr. Nash Petrovic on [longvita@yebo.co.za](mailto:longvita@yebo.co.za) or [longvita@hotmail.com](mailto:longvita@hotmail.com)  
 Fax / Phone : +27-11-884-7324 / +27-11-465-66-51  
 (both numbers are both voice and facsimile)