



FLUOROQUINOLONE TOXICITY SYNDROME SUPPLEMENTAL DOCTOR PREPARATION FORM

Name: _____ DOB: _____ Date: _____

This form was written and prepared by Quinolone Vigilance Foundation for you to bring to your doctor appointments. The more accurate your answers, the better your doctor may be able to help you. These pages contain commonly reported adverse reactions to fluoroquinolone antibiotics.

INSTRUCTIONS: Please mark checkboxes for symptoms you have experienced since starting Fluoroquinolone antibiotic: Check all that apply.

Mark LEFT column for Currently Have Symptom

Mark MIDDLE column if Had Symptom But Recovered

Mark RIGHT column if New Onset of Symptom More Than 21 Days After Stopping Drug

Musculoskeletal:

- Tendon rupture
- Tendon pain
- Joint pain
- Popping/cracking joints
- Muscle wasting
- Muscle pain
- Muscle weakness
- Back pain (circle all that apply: low back, mid back, upper back)

Other: _____

Peripheral Nervous System:

- Tingling, pins and needles, numbness in arms or legs
- Burning pain in arms or legs
- Pain with touch or hypersensitivity to pain



Mark LEFT column for Currently Have Symptom
Mark MIDDLE column if Had Symptom But Recovered
Mark RIGHT column if New Onset of Symptom More Than 21 Days After Stopping Drug

Peripheral Nervous System (continued):

- Facial nerve pain
- Sensation of pressure in head
- Muscle twitching/tremors

Other: _____

Central Nervous System:

- Brain fog
- Memory loss/impairment
- Confusion
- Abnormally vivid dreams
- Seizures

Other: _____

Autonomic Nervous System:

- Lightheadedness
- Changes in sweat response

Other: _____



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Psychiatric:

- | | | | |
|--------------------------|--------------------------|--------------------------|-------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Depersonalization |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Depression |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Suicidal ideation |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Irritability |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Anxiety / Panic |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Insomnia |

Other: _____

Dermatological:

- | | | | |
|--------------------------|--------------------------|--------------------------|-------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Itching |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dry skin/patches |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hair loss |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Loss of collagen/elasticity in skin |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Skin rash |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Poor wound healing |

Other: _____

Gastrointestinal:

- | | | | |
|--------------------------|--------------------------|--------------------------|-----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Difficulty swallowing |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Abdominal pain |



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Gastrointestinal (continued):

- | | | | |
|--------------------------|--------------------------|--------------------------|-------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Persistent diarrhea |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Persistent constipation |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nausea |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Acid reflux/GERD |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bloating/gas |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Food sensitivity |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Candida |

Other: _____

Vision:

- | | | | |
|--------------------------|--------------------------|--------------------------|-----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Trouble focusing |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Persistent dry eyes |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Light sensitivity |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Floaters/ Black spots |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Double vision |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Retinal tears |

Other: _____



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Ear/Nose/Throat:

- | | | | |
|--------------------------|--------------------------|--------------------------|------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ringing in ears |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dizziness/vertigo |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hearing loss |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ear wax changes |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dry mouth |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Taste changes |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Smell hypersensitivity |

Other: _____

Cardiovascular:

- | | | | |
|--------------------------|--------------------------|--------------------------|-----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heart palpitations |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cold hands/feet |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tachycardia |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Swelling in limbs |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Purple/red spots under skin |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Excessive/unusual bruising |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Swollen veins |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | High/low blood pressure |

Other: _____



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Endocrine:

- Excessive thirst/urination
- Unexplained weight change
- Sudden thyroid abnormalities
- Hypoglycemia

Other: _____

Reproductive:

- Changes in libido
- Testicular pain
- Ovarian cysts
- Vaginal dryness
- Changes in menstruation

Other: _____

Dental:

- Bleeding gums
- Broken teeth

Other: _____



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General:

- Fatigue
- Chemical Sensitivity
- Kidney Pain

Other: _____

Instructions: Check all that apply.

Food Sensitivities:

- Sugar
- Alcohol
- MSG
- Soy
- Gluten
- Dairy
- Nightshades (potatoes, tomatoes, eggplant, peppers)
- Acidic foods (vinegar, tomatoes, citrus)
- Sulfites
- Aspartame
- Carbonated beverages (non-alcoholic)

Other: _____

Animal Product Exacerbation:

- Beef
- Poultry
- Fish (non-shellfish)
- Shellfish (shrimp, scallops, crab, lobster, clams)
- Pork
- Lamb
- Other red meat

Other: _____



Exacerbation Triggers:

- Stress
- Lack of sleep
- Exercise beyond personal physical limitations
- Weather related storms and temperature changes
- Anxiety
- Illness
- Seasons
- Electrical sensitivity (MRI procedure)
- Ovulation
- Menstruation
- Pre- menstruation

Other: _____

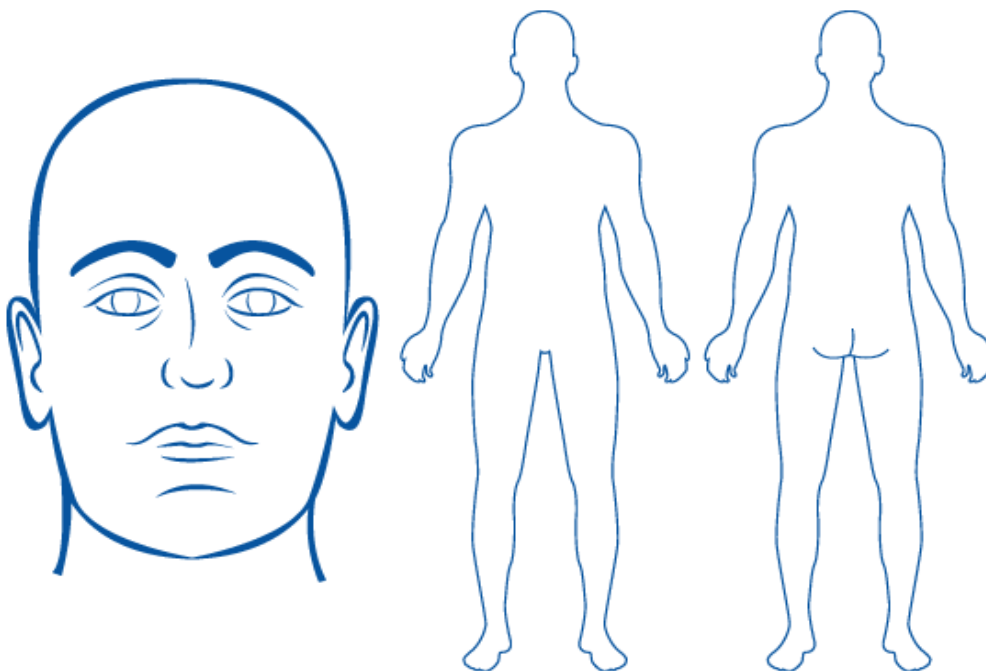
Instructions: On the diagram below, circle the part of the body where you experience symptoms using the key below.

Key:

SP= Sharp Pain
DP: Dull Pain
I=Inflammation

N=Numbness
PR=Pressure

B=Burning
W=Weakness





Hands:

Instructions: On the diagram below, circle the part of the body where you experience symptoms using the key below.

Key:

SP= Sharp Pain

DP: Dull Pain

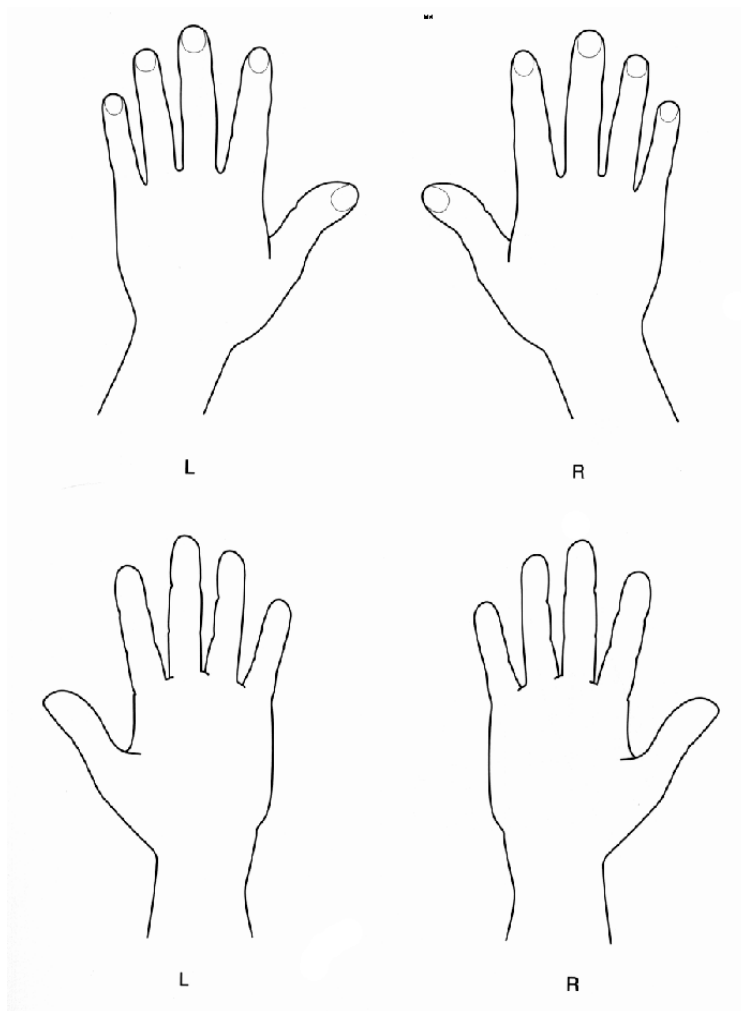
B=Burning

N=Numbness

PR=Pressure

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Feet:

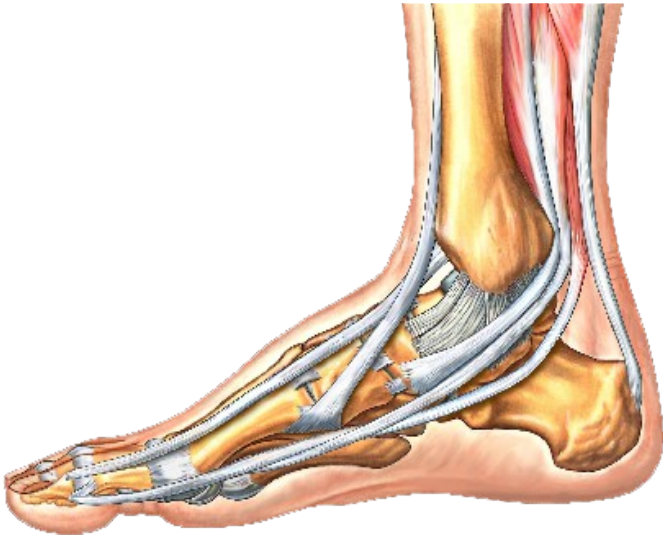
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LEFT

RIGHT





Heart/Lungs/Intestinal

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