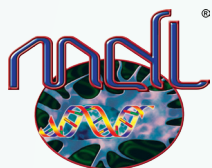


May is Lyme Awareness Month

CDC Estimates 300,000 cases of Lyme disease per year



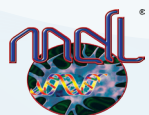
Medical Diagnostic Laboratories (MDL) offers Comprehensive Vector-Borne Disease Testing

- Detection of Lyme disease and other vector-borne diseases by DNA-based Polymerase Chain Reaction (PCR) and serology
- C6 Peptide ELISA testing for *Borrelia burgdorferi*
- Detailed results with interpretation guide with every report
- PhD's available for testing and result consultations
- MDL files all insurances including Medicare, Medicaid, PPOs and HMOs
- Patient friendly pricing for non-insured patients
- Test additions available up to 30 days after collection
- No refrigeration required before or after collection
- 7 - 14 day turnaround time

Did You Know?

- Vector-borne diseases have more than tripled in the US in recent years
- Lyme disease accounts for 82% of all tick-borne illnesses; however, Rickettsiosis, Babesiosis, Anaplasmosis & Ehrlichiosis have also increased

Contact MDL for more information...

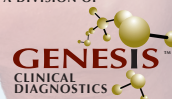


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Medical Diagnostic Laboratories, L.L.C.
Institute of Vector-Borne Diseases
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5/2019

Tick-Borne Disease Patient Symptom Checklist

Complete the checklist below based on your current symptoms. Bring the completed checklist to your next appointment for discussion with your physician.

History of tick bite? Yes No If so, when:

Symptoms	Severity	Frequency
Skin issues If yes, select all that apply:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant
	<input type="radio"/> Spotted rash over large area <input type="radio"/> EM rash in a discrete circle <input type="radio"/> Linear red streaks	
Swollen glands	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant
Sore throat	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant
Fever	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant
Joint pain If yes, select all that apply:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant
	<input type="radio"/> Fingers/Toes <input type="radio"/> Ankles/Wrists <input type="radio"/> Knees/Elbows <input type="radio"/> Hips/Shoulders	
Joint swelling If yes, select all that apply:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant
	<input type="radio"/> Fingers/Toes <input type="radio"/> Ankles/Wrists <input type="radio"/> Knees/Elbows <input type="radio"/> Hips/Shoulders	
Muscle complaints If yes, select all that apply:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant
	<input type="radio"/> Pain <input type="radio"/> Cramps <input type="radio"/> Stiffness <input type="radio"/> Weakness <input type="radio"/> Twitching	
Cognitive difficulties If yes, select all that apply:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant
	<input type="radio"/> Thinking <input type="radio"/> Concentrating <input type="radio"/> Forgetfulness <input type="radio"/> Speech errors	
Mood difficulties If yes, select all that apply:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant
	<input type="radio"/> Mood swings <input type="radio"/> Irritability <input type="radio"/> Depression <input type="radio"/> Anxiety <input type="radio"/> Panic Attacks	
Psychosis If yes, select all that apply:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant
	<input type="radio"/> Hallucinations <input type="radio"/> Delusions <input type="radio"/> Paranoia <input type="radio"/> Bipolar	
Neurological issues If yes, select all that apply:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant
	<input type="radio"/> Tremors <input type="radio"/> Seizures <input type="radio"/> Headaches <input type="radio"/> Dizziness <input type="radio"/> Off balance <input type="radio"/> Light headed	
Eye/vision difficulties If yes, select all that apply:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant
	<input type="radio"/> Sensitivity to light <input type="radio"/> Double vision <input type="radio"/> Blurry vision <input type="radio"/> Floaters	
Ear/hearing difficulties If yes, select all that apply:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant
	<input type="radio"/> Sensitivity to sound <input type="radio"/> Ear pain <input type="radio"/> Buzzing <input type="radio"/> Ringing <input type="radio"/> Decreased hearing	
Nerve issues If yes, select all that apply:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant
	<input type="radio"/> Tingling <input type="radio"/> Numbness <input type="radio"/> Burning <input type="radio"/> Stabbing <input type="radio"/> Shooting pain	
Facial paralysis/Bells Palsy	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant
Dental pain	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant
Neck pain/stiffness	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant
Fatigue, poor stamina	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant
Sleep difficulties If yes, select all that apply:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant
	<input type="radio"/> Insomnia <input type="radio"/> Broken sleep <input type="radio"/> Early waking <input type="radio"/> Excessive sleeping	
Unexplained weight gain or loss	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant
Unexplained hair loss	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant
Pain in genital area	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant
Menstrual irregularities	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant
Unusual milk production or breast pain	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant
Irritable bladder/dysfunction	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant
Erectile dysfunction or loss of sex drive	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant
Digestive difficulties If yes, select all that apply:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant
	<input type="radio"/> Nausea <input type="radio"/> Heartburn <input type="radio"/> Stomach Pain <input type="radio"/> Constipation <input type="radio"/> Diarrhea <input type="radio"/> Cramping	
Cardiac Issues If yes, select all that apply:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant
	<input type="radio"/> Heart murmur <input type="radio"/> Valve prolapse <input type="radio"/> Palpitations or skips <input type="radio"/> "Heart Block" on EKG	
Chest issues If yes, select all that apply:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant
	<input type="radio"/> Chest wall pain <input type="radio"/> Sore ribs <input type="radio"/> Breathlessness <input type="radio"/> Chronic Cough	
Head congestion	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant
Night sweats	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Occasional <input type="radio"/> Often <input type="radio"/> Constant