ADULT MEDICAL QUESTIONNAIRE

Our ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately to both these written questions and those posed by the clinician during your consultations. Health issues are usually influenced by many factors. Accurately assessing all the factors and comprehensively managing them is the best way to deal with these health challenges. Your careful consideration of each of the following questions will enhance our efficiency and will provide for more effective use of your scheduled consultation time. These questions will help to identify underlying causes of illness and will also assist us to formulate a treatment plan.

First Name: _____Middle Name: _____Last Name: _____

Address:_____ City: _____ State: _____ ZIP: _____

Home Phone: (_____) _____-_____ Birth Date: _____/____/____ Age: _____
month day year

Work Phone: (_____) _____-_____

Place of Birth:_____
City or town & country if not US

Occupation: _____

Referred by: _____ Height: ___′ ____ ″ Weight: _____ Sex: _____

Today's Date _____ Email _____

1. Please check appropriate box(es):

☐ African American ☐ Hispanic ☐ Mediterranean ☐ Asian
☐ Native American ☐ Caucasian ☐ Northern European ☐ Other

2. Please rank current and ongoing problems by priority and fill in the other boxes as completely as possible:

DESCRIBE PROBLEM	MILD/ MODERATE/ SEVERE	TREATMENT APPROACH	SUCCESS
Example: Post Nasal Drip	Moderate	Elimination Diet	Moderate
a.			
b.			
c.			
d.			
e.			
f.			
g.			
h.			

3. With whom do you live? (Include children, parents, relatives, and/or friends. Please include ages.)
   Example: Wendy, age 7, sister
   _____
   _____
   _____

4. Do you have any pets or farm animals? Yes____ No____
   If yes, where do they live? 1. _____ indoors 2. _____ outdoors 3. _____ both indoors and outdoors

5. Have you lived or traveled outside of the United States? Yes____ No____
   If so, when and where? _____
   _____

6. Have you or your family recently experienced any major life changes? Yes____ No____
   If yes, please comment: _____
   _____

7. Have you experienced any major losses in life? Yes____ No____
   If so, please comment: _____
   _____

8. How important is religion (or spirituality) for you and your family's life?
   a. _____ not at all important
   b. _____ somewhat important
   c. _____ extremely important

9. How much time have you lost from work or school in the past year?
   a. _____ 0-2 days
   b. _____ 3 –14 days
   c. _____ > 15 days

10. Previous jobs:
    _____
    _____

11. Unfortunately, abuse and violence of all kinds, verbal, emotional, physical, and sexual are leading contributors to chronic stress, illness, and immune system dysfunction; witnessing violence and abuse can also be very traumatic. If you have experienced or witnessed any kind of abuse in the past, or if abuse is now an issue in your life, it is very important that you feel safe telling us about it, so that we can support you and optimize your treatment outcomes.

    Please do your best to answer the following questions:
    a. Did you feel safe growing up?
       ☐ Yes ☐ No
    b. Have you been involved in abusive relationships in your life?
       ☐ Yes ☐ No
    c. Was alcoholism or substance abuse present in your childhood home, or is it present now in your relationships?
       ☐ Yes ☐ No
    d. Do you currently feel safe in your home?
       ☐ Yes ☐ No

e. Do you feel safe, respected and valued in your current relationship?
☐ Yes ☐ No

f. Have you had any violent or otherwise traumatic life experiences, or have you witnessed any violence or abuse?
☐ Yes ☐ No

g. Would you feel safer discussing any of these issues privately?
☐ Yes ☐ No

12. Past Medical and Surgical History:

	ILLNESSES	WHEN	COMMENTS
a.	Anemia		
b.	Arthritis		
c.	Asthma		
d.	Bronchitis		
e.	Cancer		
f.	Chronic Fatigue Syndrome		
g.	Crohn's Disease or Ulcerative Colitis		
h.	Diabetes		
i.	Emphysema		
j.	Epilepsy, convulsions, or seizures		
k.	Gallstones		
l.	Gout		
	ILLNESSES	**WHEN**	**COMMENTS**
m.	Heart attack/Angina		
n.	Heart failure		
o.	Hepatitis		
p.	High blood fats (cholesterol, triglycerides)		
q.	High blood pressure (hypertension)		
r.	Irritable bowel		
s.	Kidney stones		
t.	Mononucleosis		
u.	Pneumonia		
v.	Rheumatic fever		
w.	Sinusitis		
x.	Sleep apnea		
y.	Stroke		
z.	Thyroid disease		
aa.	Other (describe)		

	INJURIES	WHEN	COMMENTS
ab.	Back injury		
ac.	Broken (describe)		
ad.	Head injury		
ae.	Neck injury		
af.	Other (describe)		
	DIAGNOSTIC STUDIES	**WHEN**	**COMMENTS**
ag.	Barium Enema		
ah.	Bone Scan		
ai.	CAT Scan of Abdomen		
aj.	CAT Scan of Brain		
ak.	CAT Scan of Spine		
al.	Chest X-ray		
am.	Colonoscopy		
an.	EKG		
ao.	Liver scan		
ap.	Neck X-ray		
aq.	NMR/MRI		
ar.	Sigmoidoscopy		
as.	Upper GI Series		
at.	Other (describe)		
	OPERATIONS	**WHEN**	**COMMENTS**
au.	Appendectomy		
av.	Dental Surgery		
aw.	Gall Bladder		
ax.	Hernia		
ay.	Hysterectomy		
az.	Tonsillectomy		
ba.	Other (describe)		
bb.	Other (describe)		

13. Hospitalizations:

WHERE HOSPITALIZED	WHEN	FOR WHAT REASON
a.		
b.		
c.		
d.		
e.		

14. How often have you have taken antibiotics?

	< 5 times	**> 5 times**
Infancy/ Childhood		
Teen		
Adulthood		

15. How often have you have taken oral steroids (e.g., Cortisone, Prednisone, etc.)?

	< 5 times	**> 5 times**
Infancy/ Childhood		
Teen		
Adulthood		

16. What medications are you taking now? Include non-prescription drugs.

Medication Name	**Date started**	**Dosage**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Are you allergic to any medications? Yes____ No____

If yes, please list: _____

_____

17. List all vitamins, minerals, and other nutritional supplements that you are taking now. Indicate whether mg or IU and the form (e.g., calcium carbonate vs. calcium lactate), when possible.

Vitamin/Mineral/Supplement Name	**Date started**	**Dosage**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

18. Childhood:

Question	Yes	No	Don't Know	Comment
1. Were you a full term baby?				
a. A preemie?				
b. Breast fed?				
c. Bottle fed?				
2. As a child did you eat a lot of sugar and/or candy?				

19. As a child, were there any foods that you had to avoid because they gave you symptoms?
Yes____ No____
If yes, please: name the food and symptom (Example: milk – gas and diarrhea)
_____
_____
_____

20. Place a check mark next to the food/drink that applies to your current diet. (List continues on next page.)

	Usual Breakfast	√		Usual Lunch	√		Usual Dinner	√
a.	None		a.	None		a.	None	
b.	Bacon/Sausage		b.	Butter		b.	Beans (legumes)	
c.	Bagel		c.	Coffee		c.	Brown rice	
d.	Butter		d.	Eat in a cafeteria		d.	White/Yellow Rice	
e.	Cereal		e.	Eat in restaurant		e.	Carrots	
f.	Coffee		f.	Fish sandwich		f.	Coffee	
g.	Donut		g.	Juice		g.	Fish	
h.	Eggs		h.	Leftovers		h.	Green vegetables	
i.	Fruit		i.	Lettuce		i.	Juice	
j.	Juice		j.	Margarine		j.	Margarine	
k.	Margarine		k.	Mayo		k.	Milk	
l.	Milk		l.	Meat sandwich		l.	Pasta	
m.	Oat bran		m.	Milk		m.	Potato	
n.	Sugar		n.	Salad		n.	Chicken	
o	Oat Meal		o	Chicken		o	Butter	
p.	Sweet roll		p.	Salad dressing		p.	Red meat	
q.	Sweetener		q.	Soda		q.	Sandwich	
r.	Tea		r.	Soup		r.	Salad	
s.	Toast		s.	Sugar		s.	Salad dressing	
t.	Water		t.	Sweetener		t.	Soda	
u.	Wheat bran		u.	Tea		u.	Sugar	
v.	Yogurt		v.	Tomato		v.	Sweetener	
w.	Other: (List below)		w.	Water		w.	Tea	
			x.	Yogurt		x.	Water	
			y.	Other: (List below)		y.	Yellow vegetables	
						z.	Other: (List below)	
	Time of Meal			**Time of Meal**			**Time of Meal**	

21. How much of the following do you consume each week?

a.	Candy	
b.	Cheese	
c.	Chocolate	
d.	Cups of coffee containing caffeine	
e.	Cups of decaffeinated coffee or tea	
f.	Cups of hot chocolate	
g.	Cups of tea containing caffeine	
h.	Diet sodas	
i.	Ice cream	
j.	Salty foods	
k.	Slices of white bread (rolls/bagels)	
l.	Sodas with caffeine	
m.	Sodas without caffeine	

22. Are you on a special diet? Yes____ No____

_____ ovo-lacto _____ vegetarian _____ other (describe):
_____ diabetic _____ vegan _____
_____ dairy restricted _____ blood type diet _____

23. Is there anything special about your diet that we should know? Yes____ No____
If yes, please explain:
_____

24. a. Do you have symptoms <u>immediately after</u> eating, such as belching, bloating, sneezing, hives, etc.?
Yes____ No____
b. If yes, are these symptoms associated with any particular food or supplement(s)?
Yes____ No____
c. Please name the food or supplement and symptom(s). Example: Milk – gas and diarrhea.
_____
_____

25. Do you feel you have <u>delayed</u> symptoms after eating certain foods (symptoms may not be evident for 24 hours or more), such as fatigue, muscle aches, sinus congestion, etc.? Yes____ No____

26. Do you feel much **worse** when you eat a lot of :

_____high fat foods _____refined sugar (junk food)
_____high protein foods _____fried foods
_____high carbohydrate foods _____1 or 2 alcoholic drinks
(breads, pastas, potatoes) _____other _____

27. Do you feel much **better** when you eat a lot of :

_____high fat foods _____refined sugar (junk food)
_____high protein foods _____fried foods
_____high carbohydrate foods _____1 or 2 alcoholic drinks
(breads, pastas, potatoes) _____other _____

28. Does skipping a meal greatly affect your symptoms? Yes____ No____

29. Have you ever had a food that you craved or really "binged" on over a period of time?
Food craving may be an indicator that you may be allergic to that food. Yes____ No____
If yes, what food(s)? _____
_____

30. Do you have an aversion to certain foods? Yes____ No____
If yes, what foods? _____

31. Please fill in the chart below with information about your bowel movements:

a. Frequency	√	b. Color	√
More than 3x/day		Medium brown consistently	
1-3x/day		Very dark or black	
4-6x/week		Greenish color	
2-3x/week		Blood is visible.	
1 or fewer x/week		Varies a lot.	
		Dark brown consistently	
b. Consistency		Yellow, light brown	
Soft and well formed		Greasy, shiny appearance	
Often float			
Difficult to pass			
Diarrhea			
Thin, long or narrow			
Small and hard			
Loose but not watery			
Alternating between hard and loose/watery			

32. Intestinal gas:
_____Daily
_____Occasionally
_____Excessive
_____ Present with pain
_____ Foul smelling
_____ Little odor

33. a. Have you ever used alcohol? Yes____ No____
b. If yes, how often do you now drink alcohol?
___ No longer drinking alcohol
___ Average 1-3 drinks per week
___ Average 4-6 drinks per week
___ Average 7-10 drinks per week
___ Average >10 drinks per week
c. Have you ever had a problem with alcohol? Yes____ No____
If yes, please indicate time period (month/year): from _____ to _____.

34. Have you ever used recreational drugs? Yes____ No____

35. Have you ever used tobacco? Yes____ No____
If yes, number of years as a nicotine user _____. Amount per day _____. Year quit _____.
If yes, what type of nicotine have you used? _____Cigarette _____ Smokeless
_____Cigar _____Pipe _____Patch/Gum

36. Are you exposed to second hand smoke regularly? Yes____ No____

37. Do you have mercury amalgam fillings? Yes____ No____

38. Do you have any artificial joints or implants? Yes____ No____

39. Do you feel worse at certain times of the year? Yes____ No____
If yes, when? _____spring _____fall
_____summer _____winter

40. Have you, to your knowledge, been exposed to toxic metals in your job or at home? Yes____ No____
If yes, which one(s)? _____lead _____cadmium
_____arsenic _____mercury
_____aluminum

41. Do odors affect you? Yes____ No____

42. How well have things been going for you?

	Very Well	Fair	Poorly	Very Poorly	Does not apply
a. At school					
b. In your job					
c. In your social life					
d. With close friends					
e. With sex					
f. With your attitude					
g. With your boyfriend/girlfriend					
h. With your children					
i. With your parents					
j. With your spouse					

43. Have you ever had psychotherapy or counseling? Yes____ No____
Currently? _____ Previously? _____ If previously, from _____ to _____.
What kind? _____
Comments: _____

44. Are you currently, or have you ever been, married? Yes____ No____
If so, when were you married? _____ Spouse's occupation _____
When were you separated? _____ Never _____
When were you divorced? _____ Never _____
When were you remarried? _____ Never _____ Spouse's occupation _____
Comments: _____

45. Hobbies and leisure activities: _____
_____

46. Do you exercise regularly? Yes____ No____
If so, how many times a week?
1._____1x
2._____2x
3._____3x
4._____4x or more

When you exercise, how long is each session?
1._____ ≤15 min
2._____ 16-30 min
3._____ 31-45 min
4._____ > 45 min

47. FAMILY HISTORY: For each member of your family, follow the grey or white line across the page and check the boxes for:

1. Their present state of health, and
2. Any illnesses they have had.

*(Note: Except for **spouse**, Family refers to **blood** or **natural** relatives.)* **PRINT NAMES BELOW**	Good Health	Poor Health	Deceased	Write in age and cause of death. Include accidents and suicides.	Alcoholism	Allergies or Asthma	Alzheimer's or Dementia	Anemia	Blood Clotting Problems	Diabetes	Cancer or Tumor	Epilepsy	Genetic Disease	Heart Trouble	High Blood Pressure	Kidney or Bladder Dis.	Nervous Breakdown	Rheumatism or Arthritis	Stomach or Duodenal Ulcer
Father																			
Mother:																			
Brothers/Sisters:																			
Spouse:																			
Child:																			
Child:																			
Child:																			
Child:																			
Paternal relatives (in each box, write in how many affected with condition):																			
Maternal relatives (in each box, write in how many affected with condition):																			

What type of exercise is it?

_____jogging/walking _____tennis
_____basketball _____water sports
_____home aerobics _____other _____

47. Any other family history we should know about? Yes____ No____
If so, please comment: _____

48. What is the attitude of those close to you about your illness?
_____Supportive
_____Non-supportive

****MEN SKIP TO QUESTION # 61****

49. Have you ever been pregnant? (If no, skip to question 53.) Yes____ No____

Number of miscarriages _____ Number of abortions _____ Number of preemies _____

Number of term births _____ Birth weight of largest baby _____ Smallest baby _____

Did you develop toxemia (high blood pressure)? Yes____ No____

Have you had other problems with pregnancy? Yes____ No____

If so, please comment:

_____

_____

50. Age at first period _____ Date of last Pap Smear _____ Date of last Mammogram_____
Pap Smear: ___ Normal ___Abnormal
Mammogram: ___ Normal ___ Abnormal

51. Have you ever used birth control pills? Yes____ No____ If yes, when _____

52. Are you taking the pill now? Yes____ No____

53. Did taking the pill agree with you? Yes____ No____ Not applicable _____

54. Do you currently use contraception? Yes____ No____
If yes, what type of contraception do you use? _____

55. Are you in menopause? No _____ Yes _____ If yes, age at last period_____
Do you take: Estrogen?___ Ogen?___ Estrace?___ Premarin?___ Other (specify)_____
Progesterone?___ Provera? ___ Other (specify) _____

56. How long have you been on hormone replacement therapy (if applicable)? _____

57. In the second half of your cycle, do you have symptoms of breast tenderness, water retention, or irritability (PMS)? Yes____ No____ Not applicable _____

Date of last PAP smear? _____ Physician who performed? _____

Physician's Phone Number: _____.

Date of last mammogram? _____ Facility where performed:_____

Facility Phone Number: _____.

	YES	NO
Have you ever had an abnormal PAP smear? If yes, what was the abnormality and what follow up did you have? _____ _____		
Have you ever had an abnormal mammogram? If yes, what was the abnormality and what follow up did you have? _____ _____		
Have you ever had a breast biopsy?		
Have you ever had a cervical biopsy?		
Have you noticed breast skin or nipple changes?		
Have you noticed any lumps in your breasts?		
Are you using a birth control method? If yes, what kind?		
Are you still having menstrual periods? If yes, when was the first day of you last period? _____.		

Please describe any problems, if any, you have with your periods.

Periods are (were) □ regular □ irregular □ painful □ crampy □ heavy □ light

Age periods began:_____ # days of bleeding_____ cycle length_____

If you are no longer having periods, at what age did you periods stop? _____
If your periods stopped less than one year ago, how many months ago was your last period? _____

Did your periods stop because you had a hysterectomy? □ Yes □ No

- If yes what was the reason for the surgery? _____
- Were the ovaries removed at the same time? □ Yes □ No □ Not Sure

Do you have a history of any of the following **cancers**:

□ Vulva	□ Ovary	□ Other:
□ Uterus	□ Fallopian Tube	
□ Vagina	□ Breast	
□ Cervix	□ Colon	

59.

Have you been treated with any hormone replacement therapy? If yes, please give approximate periods of treatment:

Hormone	Dose	Reason	Start Date	Stop Date

Estrogen Deficiency	**Estrogen Excess / Progesterone Deficiency**	
☐ Hot Flashes	☐ Mood Swings (PMS)	☐ Uterine Fibroids
☐ Night Sweats	☐ Cystic Ovaries	☐ Weight Gain - Hips
☐ Vaginal Dryness	☐ Tender Breasts	☐ Bleeding Changes
☐ Foggy Thinking	☐ Heavy Menses	☐ Elevated Triglycerides
☐ Memory Lapses	☐ Water Retention	☐ Breast Cancer
☐ Urinary Incontinence	☐ Sugar Craving	☐ Low Libido
☐ Tearful	☐ Nervousness	
☐ Depressed	☐ Irritable	
☐ Sleep Disturbances	☐ Anxious	
☐ Heart Palpitations	☐ Fibrocystic Breast	
☐ Bone Loss	☐ Headaches	
☐ Headaches	☐ Cold Body Temperature	

Androgen Excess	**Androgen Deficiency**	
☐ Increased Facial Hair	☐ Low Libido	☐ Heart Palpitations
☐ Increased Body Hair	☐ Vaginal Dryness	☐ Headaches
☐ Acne	☐ Fatigue	☐ Fibromyalgia
☐ Oily Skin	☐ Aches/Pains	☐ Irritable
☐ Nervous	☐ Memory Lapses	☐ Thinning Skin
☐ Irritable	☐ Foggy Thinking	
☐ Anxious	☐ Urinary Incontinence	
☐ Depressed	☐ Depressed	
☐ Ovarian Cysts	☐ Anxious	
☐ Elevated Triglycerides	☐ Sleep Disturbances	
☐ Sleep Disturbances	☐ Bone Loss	
☐ Breast Cancer	☐ Decreased Muscle Mass	

60.

Cortisol Excess		Cortisol Deficiency
☐ Sleep Disturbances	☐ Heart Palpitations	☐ Fatigue
☐ Bone Loss	☐ Headaches	☐ Sugar Craving
☐ Fatigue	☐ Stress	☐ Allergies
☐ Weight Gain - Waist	☐ Cold Body Temperature	☐ Chemical Sensitivity
☐ Loss of Muscle Mass	☐ Sugar Cravings	☐ Stress
☐ Thinning Skin	☐ Low Libido	☐ Cold Body Temperature
☐ Elevated Triglycerides	☐ Hair Loss	☐ Irritable
☐ Breast Cancer	☐ Increased Facial Hair	☐ Arthritis
☐ Irritable	☐ Increased Body Hair	☐ Heart Palpitations
☐ Anxious	☐ Acne	☐ Aches/Pains
☐ Memory	☐ Nervous	

Thyroid Excess	Thyroid Deficiency
☐ Heat Intolerance	☐ Cold Intolerance
☐ Voice has become horse	☐ Constipation
☐ Palpitations	☐ Fatigued / Weakness
☐ Weight Loss	☐ Unexplained Weight Gain
☐ Tremors / Shakiness	☐ Inability to Loose Weight
☐ Diarrhea	☐ Stress
☐ Nervousness / Anxious / Panic Attacks	☐ Cold Body Temperature
☐ Muscle Weakness	☐ Irritable
☐ Difficulty Conceiving / Infertility	☐ Lack of Motivation
☐ Coarse Dry Skin	☐ Muscle Cramps
☐ Insomnia	☐ Aches/Pains

Male Urological History

Date of last prostate exam? _____ Physician who performed? _____

Physician's Phone Number: _____.

Date of PSA blood work/? _____ Facility/Office where performed: _____

Facility/Office Phone Number: _____.

	YES	NO
Have you ever had an abnormal Prostate Exam? If yes, what was the abnormality and what follow up did you have? _____		
Have you ever had an elevated PSA? If yes, what follow up did you have?		
Have you ever had a prostate biopsy?		

Do you have a history of any of the following **cancers**:

☐ Lung	☐ Skin	☐ Other:
☐ Breast	☐ Lymphoma	
☐ Colon	☐ Leukemia	
☐ Prostate		

Hormone Therapy History

Have you been treated with any hormone replacement therapy? If yes, please give approximate periods of treatment:

Hormone	Dose	Reason	Start Date	Stop Date

Androgen Deficiency

☐ Low Libido	☐ Decreased Erections
☐ Lack of Energy	☐ Decreased Ability to Play Sports
☐ Decreased Strength / Endurance	☐ Fall Asleep After Dinner
☐ Lost Height	☐ Sleep Disturbances
☐ Decreased Enjoyment of Life	☐ Recent Deterioration in Work Performance
☐ Sad or Grumpy	☐ Decreased Muscle Mass
☐ Problem with Memory / Concentration	☐ Hair Loss

59. Please check if these symptoms occur presently **or** have occurred in the past 6 months.

GENERAL:	Mild	Mod-erate	Severe
Cold hands & feet			
Cold intolerance			
Daytime sleepiness			
Difficulty falling asleep			
Early waking			
Fatigue			
Fever			
Flushing			
Heat intolerance			
Night waking			
Nightmares			
No dream recall			
HEAD, EYES & EARS:			
Conjunctivitis			
Distorted sense of smell			
Distorted taste			
Ear fullness			
Ear noises			
Ear pain			
Ear ringing/buzzing			
Eye crusting			
Eye pain			
Headache			
Hearing loss			
Hearing problems			
Lid margin redness			
Migraine			
Sensitivity to loud noises			
Vision problems			

MUSCULOSKELETAL:	Mild	Mod-erate	Severe
Back muscle spasm			
Calf cramps			
Chest tightness			
Foot cramps			
Joint deformity			
Joint pain			
Joint redness			
Joint stiffness			
Muscle pain			
Muscle spasms			
Muscle stiffness			
Muscle twitches: Around eyes			
Arms or legs			
Muscle weakness			
Neck muscle spasm			
Tendonitis			
Tension headache			
TMJ problems			
MOOD/NERVES:			
Agoraphobia			
Anxiety			
Auditory hallucinations			
Black-out			
Depression			
Difficulty: Concentrating			
With balance			
With thinking			
With judgment			
With speech			
With memory			
Dizziness (spinning)			
Fainting			
Fearfulness			
Irritability			
Light-headedness			

MOOD/NERVES, Cont'd:	Mild	Mod-erate	Severe
Numbness			
Other Phobias			
Panic attacks			
Paranoia			
Seizures			
Suicidal thoughts			
Tingling			
Tremor/trembling			
Visual hallucinations			
EATING:			
Binge eating			
Bulimia			
Can't gain weight			
Can't lose weight			
Carbohydrate craving			
Carbohydrate intolerance			
Poor appetite			
Salt craving			
DIGESTION:			
Anal spasms			
Bad teeth			
Bleeding gums			
Bloating of: Lower abdomen			
Whole abdomen			
Blood in stools			
Burping			
Canker sores			
Cold sores			
Constipation			
Cracking at corner of lips			
Dentures w/poor chewing			
Diarrhea			
Difficulty swallowing			
Dry mouth			
Farting			

DIGESTION, Cont'd:	Mild	Mod-erate	Severe
Fissures			
Foods "repeat" (reflux)			
Heartburn			
Hemorrhoids			
Intolerance to: Lactose			
All milk products			
Intolerance to: Gluten (wheat)			
Corn			
Eggs			
Fatty foods			
Yeast			
Liver disease/jaundice (yellow eyes or skin)			
Lower abdominal pain			
Mucus in stools			
Nausea			
Periodontal disease			
Sore tongue			
Strong stool odor			
Undigested food in stools			
Upper abdominal pain			
Vomiting			
SKIN PROBLEMS:			
Acne on back			
Acne on chest			
Acne on face			
Acne on shoulders			
Athlete's foot			
Bumps on back of upper arms			
Cellulite			
Dark circles under eyes			
Ears get red			
Easy bruising			

SKIN PROBLEMS, Cont'd:	Mild	Mod-erate	Severe
Eczema			
Herpes - genital			
Hives			
Jock itch			
Lackluster skin			
Moles w color/size change			
Oily skin			
Pale skin			
Patchy dullness			
Psoriasis			
Rash			
Red face			
Sensitive to bites			
Sensitive to poison ivy/oak			
Shingles			
Skin cancer			
Skin darkening			
Strong body odor			
Thick calluses			
Vitiligo			
SKIN, ITCHING:			
Anus			
Arms			
Ear canals			
Eyes			
Feet			
Hands			
Legs			
Nipples			
Nose			
Penis			
Roof of mouth			
Scalp			
Skin in general			
Throat			

SKIN, DRYNESS OF:	Mild	Mod-erate	Severe
Eyes			
Feet			
Any cracking?			
Any peeling?			
Hair			
And unmanageable?			
Hands			
Any cracking?			
Any peeling?			
Mouth/throat			
Scalp			
Any dandruff?			
Skin in general			
LYMPH NODES:			
Enlarged/neck			
Tender/neck			
Other enlarged/tender lymph nodes			
NAILS:			
Bitten			
Brittle			
Curve up			
Frayed			
Fungus - fingers			
Fungus - toes			
Pitting			
Ragged cuticles			
Ridges			
Soft			
Thickening of: Finger nails			
Toenails			
White spots/lines			

RESPIRATORY:	Mild	Mod-erate	Severe
Bad breath			
Bad odor in nose			
Cough - dry			
Cough - productive			
Hay fever : Spring			
Summer			
Fall			
Change of season			
Hoarseness			
Nasal stuffiness			
Nose bleeds			
Post nasal drip			
Sinus fullness			
Sinus infection			
Snoring			
Sore throat			
Wheezing			
Winter stuffiness			
CARDIOVASCULAR:			
Angina/chest pain			
Breathlessness			
Heart attack			
Heart murmur			
High blood pressure			
Irregular pulse			
Mitral valve prolapse			
Palpitations			
Phlebitis			
Swollen ankles/feet			
Varicose veins			

URINARY:	Mild	Mod-erate	Severe
Bed wetting			
Hesitancy			
Infection			
Kidney disease			
Kidney stone			
Leaking/incontinence			
Pain/burning			
Prostate enlargement			
Prostate infection			
Urgency			
MALE REPRODUCTIVE:			
Discharge from penis			
Ejaculation problem			
Genital pain			
Impotence			
Infection			
Lumps in testicles			
Poor libido (sex drive)			
FEMALE REPRODUCTIVE:			
Breast cysts			
Breast lumps			
Breast tenderness			
Ovarian cyst			
Poor libido (sex drive)			
Endometriosis			
Fibroids			
Infertility			
Vaginal discharge			
Vaginal odor			
Vaginal itch			
Vaginal pain			