Cleveland Clinic
Wellness

Tanya I. Edwards, MD
Center for Integrative Medicine
Medical History Intake Form

Today's Date _____

General Information

First Name _____ Middle Name _____ Last Name _____

Preferred Name _____

Date of Birth _____ Age _____

Height _____' _____" Weight _____ Gender ❒ Male ❒ Female

Primary Language _____ Secondary Language _____

Occupation _____

Place of Birth _____ City/ Town and Country if not U.S. _____

Highest Education Level ❒High School ❒Graduate ❒Post Graduate

Primary Address Address _____ Apt #_____

City _____ State _____ Zip _____

Alternate Address Address _____ Apt# _____

City _____ State _____ Zip _____

Home Phone _____

Work Phone _____

Cell Phone _____

E-Mail _____ Fax _____

Emergency Contact Name _____ Phone Number _____

Address _____ Apt # _____

City _____ State _____ Zip _____

Physician Name _____

Phone Number _____ Fax _____

Referred By _____

PHARMACY INFORMATION

Primary Pharmacy Name _____ Phone Number _____

Address _____ City _____ State _____ Zip _____

Fax* _____ E-mail _____

**It is extremely important that you list the pharmacy's fax number*

Compounding/ Supplement Pharmacy Name _____ Phone Number _____

Address _____ City _____ State _____ Zip _____

Fax* _____ E-mail _____

**It is extremely important that you list the pharmacy's fax number*

Medical Questionnaire

What are your expectations and goals for this visit? _____

_____

_____

HEALTH CONCERNS

When was the last time you felt well? _____

Did something trigger your change in health? _____

What makes you feel better? _____

_____

What makes you feel worse? _____

_____

Please rank current and ongoing problems by priority

DESCRIBE PROBLEM	MILD/MODERATE/SEVERE	TREATMENT APPROACH	SUCCESS
Example: Post Nasal Drip	Moderate	Elimination Diet	Moderate

ALLERGIES

MEDICATION/ SUPPLEMENT/ FOOD	REACTION

Do you live with a pet? ☐Yes ☐No Any reactions? ☐Yes ☐No What kind? _____ How many _____ How long _____

MEDICAL HISTORY

❒ =Past Condition ❒ =Ongoing Condition

Diseases/ Diagnosis/ Conditions *Check appropriate box and provide date of onset*

GASTROINTESTINAL

- ❒ ❒ Irritable Bowel Syndrome _____
- ❒ ❒ Inflammatory Bowel Disease _____
- ❒ ❒ Crohn's _____
- ❒ ❒ Ulcerative Colitis _____
- ❒ ❒ Gastric or Peptic Ulcer Disease _____
- ❒ ❒ GERD (reflux) _____
- ❒ ❒ Celiac Disease _____
- ❒ ❒ Other _____

CARDIOVASCULAR

- ❒ ❒ Heart Attack _____
- ❒ ❒ Other Heart Disease _____
- ❒ ❒ Stroke _____
- ❒ ❒ Elevated Cholesterol _____
- ❒ ❒ Arrythmia (irregular heart rate) _____
- ❒ ❒ Hypertension (high blood pressure) _____
- ❒ ❒ Rheumatic Fever _____
- ❒ ❒ Mitral Valve Prolapse _____
- ❒ ❒ Other _____

METABOLIC/ ENDOCRINE

- ❒ ❒ Type 1 Diabetes _____
- ❒ ❒ Type 2 Diabetes _____
- ❒ ❒ Hypoglycemia _____
- ❒ ❒ Metabolic Syndrome _____
- ❒ ❒ (insulin resistance or pre-diabetes)
- ❒ ❒ Hypothyroidism (low thyroid) _____
- ❒ ❒ Hyperthyroidism (overactive thyroid) _____
- ❒ ❒ Endocrine Problems _____
- ❒ ❒ Polycystic Ovarian Syndrome (PCOS) _____
- ❒ ❒ Infertility _____
- ❒ ❒ Weight Gain _____
- ❒ ❒ Weight Loss _____
- ❒ ❒ Frequent Weight Fluctuations _____
- ❒ ❒ Bulimia _____
- ❒ ❒ Anorexia _____
- ❒ ❒ Binge Eating Disorder _____
- ❒ ❒ Night Eating Syndrome _____
- ❒ ❒ Eating Disorder (non-specific) _____
- ❒ ❒ Other _____

CANCER

- ❒ ❒ Lung Cancer _____
- ❒ ❒ Breast Cancer _____
- ❒ ❒ Colon Cancer _____
- ❒ ❒ Ovarian Cancer _____
- ❒ ❒ Prostate Cancer _____
- ❒ ❒ Skin Cancer _____
- ❒ ❒ Other _____

GENITAL AND URINARY SYSTEMS

- ❒ ❒ Kidney Stones _____
- ❒ ❒ Gout _____
- ❒ ❒ Interstitial Cystitis _____
- ❒ ❒ Frequent Urinary Tract Infections _____
- ❒ ❒ Frequent Yeast infections _____
- ❒ ❒ Erectile Dysfunction _____
- ❒ ❒ Or sexual Dysfunction _____
- ❒ ❒ Other _____

MUSCULOSKELETAL / PAIN

- ❒ ❒ Osteoarthritis _____
- ❒ ❒ Fibromyalgia _____
- ❒ ❒ Chronic Pain _____
- ❒ ❒ Other _____

INFLAMMATORY/ AUTOIMMUNE

- ❒ ❒ Chronic Fatigue Syndrome _____
- ❒ ❒ Autoimmune Disease _____
- ❒ ❒ Rheumatoid Arthritis _____
- ❒ ❒ Lupus SLE _____
- ❒ ❒ Immune Deficiency Disease _____
- ❒ ❒ Herpes- Genital _____
- ❒ ❒ Severe Infectious Disease _____
- ❒ ❒ Poor Immune Function _____
- ❒ ❒ (Frequent infections)
- ❒ ❒ Food Allergies _____
- ❒ ❒ Environmental Allergies _____
- ❒ ❒ Multiple Chemical Sensitivities _____
- ❒ ❒ Latex Allergy _____
- ❒ ❒ Other _____

RESPIRATORY DISEASES

- ❒ ❒ Asthma _____
- ❒ ❒ Chronic Sinusitis _____
- ❒ ❒ Bronchitis _____
- ❒ ❒ Emphysema _____
- ❒ ❒ Pneumonia _____
- ❒ ❒ Tuberculosis _____
- ❒ ❒ Sleep Apnea _____
- ❒ ❒ Other _____

SKIN DISEASES

- ❒ ❒ Eczema _____
- ❒ ❒ Psoriasis _____
- ❒ ❒ Acne _____
- ❒ ❒ Melanoma _____
- ❒ ❒ Skin Cancer _____
- ❒ ❒ Other _____

NEUROLOGIC/ MOOD

- ❒ ❒ Depression _____
- ❒ ❒ Anxiety _____
- ❒ ❒ Bipolar Disorder _____
- ❒ ❒ Schizophrenia _____
- ❒ ❒ Headaches _____
- ❒ ❒ ADD/ADHD _____
- ❒ ❒ Autism _____
- ❒ ❒ Mild Cognitive Impairment _____
- ❒ ❒ Memory Problems _____
- ❒ ❒ Parkinson's Disease _____
- ❒ ❒ Multiple Sclerosis _____
- ❒ ❒ ALS _____
- ❒ ❒ Seizures _____
- ❒ ❒ Other _____

PREVENTIVE TESTS AND DATE OF LAST TEST

Check box if yes and provide date

- ❒ Full Physical Exam _____
- ❒ Bone Density _____
- ❒ Colonoscopy _____
- ❒ Cardiac Stress Test _____
- ❒ EKG _____
- ❒ Hemoccult Test- stool test for blood _____
- ❒ MRI _____
- ❒ CT Scan _____
- ❒ Upper Endoscopy _____
- ❒ Upper GI Series _____
- ❒ Ultrasound _____
- ❒ X-rays _____

SURGERIES

Check box if yes and provide date of surgery

- ❒ Appendectomy _____
- ❒ Hysterectomy +/- Ovaries _____
- ❒ Gall Bladder _____
- ❒ Hernia _____
- ❒ Tonsillectomy _____
- ❒ Dental Surgery _____
- ❒ Joint Replacement – knee/ hip _____
- ❒ Heart Surgery – bypass valve _____
- ❒ Angioplasty or Stent _____
- ❒ Pacemaker _____
- ❒ Other _____
- ❒ None _____

INJURIES

❒ Back Injury ❒ Head Injury ❒ Neck Injury ❒ Broken Bones ❒ Other _____

Do you have any artificial joints or implants? ❒ Yes ❒No

HOSPITALIZATIONS ❒ None

DATE	REASON

PATIENT BIRTH HISTORY

❒ Term ❒ Premature

Pregnancy Complications _____ Birth Complications _____

❒ Breast Fed How long? _____ ❒ Bottle-fed Did you eat a lot of candy or sugar as a child? ❒ Yes ❒ No

Age at introduction of: Solid Foods _____ Dairy _____ Wheat _____

GYNECOLOGIC HISTORY *(FOR WOMEN ONLY)*

Obstetric History *Check box if yes and provide number of*

❒ Pregnancies ____ ❒ Caesarean ____ ❒ Vaginal Deliveries _____ ❒ Miscarriage _____ ❒ Abortion _____ ❒ Living Children _____

❒ Post-Partum Depression _____ ❒ Toxemia _____ ❒ Gestational Diabetes _____ ❒ Baby over 8 pounds _____

❒ Breast Feeding- For how long? _____

Menstrual History

Age at first period _____ Menses Frequency _____ Length _____ Pain ❒ Yes ❒ No Clotting ❒ Yes ❒ No

Has your period ever skipped? ❒ Yes ❒ No For how long? _____ Date of Last Menstrual Period _____

Use of Birth Control Pills ❒ Yes ❒ No How long? _____

Do you use contraception? ❒ Yes ❒ No Type: ❒ Condom ❒ Diaphragm ❒ IUD ❒ Partner Vasectomy

Women's Disorder Hormonal Imbalances

❒ Fibrocystic Breasts ❒Endometriosis ❒Fibroids ❒ Infertility ❒ Painful Periods ❒ Heavy Periods ❒ PMS

Last Mammogram _____ **❒ Breast Biopsy/ Date** _____

Last PAP Test _____ **❒ Normal ❒ Abnormal**

Date of Last Bone Density _____ **Results: ❒ High ❒ Low ❒ Within Normal Range**

Are you in menopause? ❒ Yes ❒ No Age at Menopause _____

❒Hot Flashes ❒Mood Swings ❒Concentration/ Memory Problems ❒Vaginal Dryness ❒Decreased Libido

❒Heavy Bleeding ❒Joint Pains ❒Headaches ❒Weight Gain ❒Loss of Control of Urine ❒Palpitations

❒Use of hormone replacement therapy? ❒ Yes ❒ No How long? _____

In second half of your cycle, do you have symptoms of breast tenderness, water retention or irritability (PMS)? ❒ Yes ❒ No

Sexual Patterns

Do you have any questions about sex? ❒ Yes ❒ No Is your present sex life satisfactory? ❒ Yes ❒ No

Do you have pain or discomfort with sexual intercourse? ❒ Yes ❒ No How many partners have you had in the past 10 years? _____

Have you ever had a sexually transmitted disease? ❒ Yes ❒ No

MEN'S HISTORY *(FOR MEN ONLY)*

Have you had a PSA done? ❒ Yes ❒ No PSA Level: ❒0-2 ❒2-4 ❒4-10 ❒>10

❒Prostate Enlargement ❒Prostate Infection ❒Change in Libido ❒Impotence ❒Difficulty Obtaining an Erection

❒Difficulty Maintaining an Erection ❒Urgency/ Hesitancy/ Change in Urinary Stream

❒Nocturia (urination at night) How many times at night? _____ ❒Loss of Control of Urine

Do you have any questions about sex? ❒ Yes ❒ No Is your present sex life satisfactory? ❒ Yes ❒ No

Do you have pain or discomfort with sexual intercourse? ❒ Yes ❒ No How many partners have you had in the past 10 years? _____

Have you ever had a sexually transmitted disease? ❒ Yes ❒ No

MEDICATION AND NUTRITIONAL SUPPLEMENTS

Current Medications

MEDICATION	DOSAGE	FREQUENCY	START DATE (MONTH/YEAR)	REASON FOR USE

Any hormones (estrogens, progesterone, DHEA, testosterone, growth hormone, steroids) _____

Current Nutritional Supplements (Vitamins, Minerals, Herbs, Homeopathy)

SUPPLEMENT & BRAND	DOSAGE	FREQUENCY	START DATE (MONTH/YEAR)	REASON FOR USE

Have your medications or supplements ever caused you any side effects or problems? ❒ Yes ❒ No

Describe _____

Have you had prolonged or regular use of NSAIDs? (Advil, Aleve, etc.) Motrin, Aspirin? ❒ Yes ❒ No

Have you had prolonged or regular use of Tylenol? ❒ Yes ❒ No

Have you had prolonged or regular use of Acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc.?) ❒ Yes ❒ No

Use of steroids (prednisone, nasal allergy inhalers) in the past? ❒ Yes ❒ No

Use of oral contraceptives? ❒ Yes ❒ No

Long term antibiotics? ❒ Yes ❒ No

How often have you taken antibiotics:

Infancy/ Childhood: ❒<5 times ❒>5 times Teen: ❒<5 times ❒>5 times Adulthood: ❒<5 times ❒>5 times

IMMUNIZATIONS/ VACCINATIONS

CHECK ANY YOU RECEIVED	X	DATE	BOOSTERS	X	DATE	DESCRIBE ANY ADVERSE REACTIONS
Smallpox			Within past 7 years?			
DPT						
Diptheria						
Pertussis						
Tetanus			Tetanus booster?			
Measles						
Mumps						
Rubella						
Polio			Within past 2 years?			
Hepatitis						
Influenza			Your last flu shot?			
Pneumovax						
Other						

Have you been out of the country in the last 2 years? ❒ Yes ❒ No When? _____ Where? _____

Tuberculin (TB) Skin Test: ❒ Yes ❒ No Date: _____ Result: ❒ Positive ❒ Negative

FAMILY HISTORY

Check family members that apply	Mother	Father	Brother(S)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Other
Age (if still alive)												
Age at Death (if deceased)												
Cancers												
Colon Cancer												
Breast or Ovarian Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing Spondylitis)												
Inflammatory Bowel Disease												
Multiple Sclerosis												
Auto Immune Disease (such as Lupus)												
Irritable Bowel Syndrome												
Celiac Disease												
Asthma												
Eczema/ Psoriasis												
Food Allergies, Sensitivities or Intolerances												
Environmental Sensitivities												
Dementia												
Parkinson's												
ALS or other Motor Neuron Diseases												
Genetic Disorders												
Substance Abuse (such as alcoholism)												
Psychiatric Disorders												
Depression												
Schizophrenia												
ADHD												
Autism												
Bipolar Disease												

GI HISTORY

Have you traveled outside of the U.S.? ❒ Yes ❒ No If yes, where? _____

Wilderness Camping? ❒ Yes ❒ No Where? _____

Have you ever had severe ❒Gastroenteritis ❒Diarrhea

DENTAL HISTORY

❒Silver Mercury Fillings How many? _____

❒Gold Fillings ❒Root Canals Implants ❒Tooth Pain ❒Bleeding Gums ❒Gingivitis ❒Problems with Chewing

How often do you brush your teeth? _____ How many minutes each time? _____

Do you use fluoridated toothpaste? ❒ Yes ❒ No

What type of dental floss do you use? ❒Waxed ❒Unwaxed ❒None How often do you floss? _____

Social History

NUTRITION

Have you ever had a nutrition consultation? ❒ Yes ❒ No

Have you made any changes in your eating habits because of your health? ❒ Yes ❒ No

Describe _____

Are you on a special diet? ❒ Yes ❒ No *Check all that apply*

❒Low Fat ❒Low Carbohydrate ❒High Protein ❒Low Sodium ❒Diabetic ❒No Dairy ❒No Wheat

❒No Gluten ❒Vegetarian ❒Vegan ❒Ovo-Lacto ❒Other/Describe _____

How often do you weigh yourself? ❒Daily ❒ Weekly ❒Monthly ❒Rarely ❒Never

Do you avoid any foods? ❒ Yes ❒ No If yes, what foods and reason? _____

_____

Do you crave any foods? ❒ Yes ❒ No What foods? _____

Do you grocery shop? ❒ Yes ❒ No If no, who does the shopping? _____

Do you cook? ❒ Yes ❒ No If no, who does the cooking? _____

How many meals do you eat out per week? ❒0-1 ❒2-3 ❒4-5 ❒>5 meal per week

Do you have symptoms immediately after eating, such as belching, bloating, sneezing, hives? ❒ Yes ❒ No

a) If yes, are these symptoms associated with any particular food or supplement? _____

b) Please name the food or supplement and the symptoms. **Example:** Milk- gas and diarrhea

_____

Do you feel you have delayed 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 Describe _____

Does skipping a meal greatly affect your symptoms? ❒ Yes ❒ No

ALCOHOL, TOBACCO, SUBSTANCE USE

Alcohol

Have you ever used alcohol? ❒ Yes ❒ No

How many drinks currently per week? (1 drink= 5oz wine, 12oz beer, 1.5oz spirits) ❒None ❒1-3 ❒4-6 ❒7-10 ❒>10

Previous alcohol intake? ❒Mild ❒Moderate ❒High ❒None *If "None" skip to Tobacco*

Have you ever been told you should cut down your alcohol intake? ❒ Yes ❒ No

Do you get annoyed when people ask you about your drinking? ❒ Yes ❒ No

Do you ever feel guilty about your alcohol consumption? ❒ Yes ❒ No Do you ever take an eye-opener? ❒ Yes ❒ No

Have you ever been unable to remember what you did during a drinking episode? ❒ Yes ❒ No

Have you ever been arrested or hospitalized because of drinking? ❒ Yes ❒ No

Have you ever thought about getting help to control or stop your drinking? ❒ Yes ❒ No

Tobacco

Have you ever used tobacco? ❒ Yes ❒ No

Do you currently smoke? ❒ Yes ❒ No How many years? _____ How many packs a day? _____

Previous smoking: How many years? _____ How many packs a day? _____

Number of attempts to quit _____ Are you exposed to second-hand smoke regularly? ❒ Yes ❒ No

Other Substances

Caffeine Intake: ❒ Yes ❒ No Cups/day: ❒ Coffee/ ❒ Tea ❒ 1 ❒ 2-4 ❒>4/day

Caffeinated Soda or Diet Soda Intake: ❒ Yes ❒ No Cups/day: ❒ 1 ❒ 2-4 ❒>4/day

Green Tea Intake: ❒ Yes ❒ No Cups/day: ❒ 1 ❒ 2-4 ❒>4/day

How many glasses of water do you drink a day? ❒ 1 ❒ 2-4 ❒>4/day ❒Tap ❒Spring ❒Well ❒Filtered ❒Distilled

Are you currently using any recreational drugs? ❒ Yes ❒ No Type _____

Have you ever used IV or inhaled recreational drugs? ❒ Yes ❒ No Have you ever been treated for drug abuse? ❒ Yes ❒ No

SAFETY

Do you use sunscreen regularly? ❒ Yes ❒ No How often? _____ What Brand? _____

Do you wear a seat belt? ❒ Yes ❒ No

EXERCISE

Do you exercise regularly? ❒ Yes ❒ No

Current Exercise Program

ACTIVITY	TYPE	FREQUENCY/ WEEK	DURATION IN MINUTES
Stretching			
Cardio/ Aerobics			
Strength			
Other (yoga, pilates)			
Sports (golf, tennis)			

Do you feel you have time to exercise? ❒ Yes ❒ No Do you feel unusually fatigued after exercise? ❒ Yes ❒ No

List problems that limit activity: _____

PSYCHOSOCIAL

Are you happy? ❒ Yes ❒ No Do you enjoy your work? ❒ Yes ❒ No Do you take vacations? ❒ Yes ❒ No

Have you made significant occupational changes in the last 10 years? ❒ Yes ❒ No If yes, describe them briefly: _____

_____

What gives your life meaning and purpose? _____

What does health mean to you? _____

_____

What do you do for fun? _____

What interests/hobbies do you have? _____

Do you have any insight into your illness? _____

How important is religion or spirituality in your life?

❒Not at all important ❒Somewhat important ❒Extremely important

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.

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/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

SLEEP

Do you have problems with sleep? ❒ Yes ❒ No Do you have trouble falling asleep? ❒ Yes ❒ No

If you awaken during the night, how often? _____ Do you have trouble falling back asleep? ❒ Yes ❒ No

Do you snore? ❒ Yes ❒ No Do you use sleeping aids? ❒ Yes ❒ No Describe _____

Average number of hours you sleep at night ❒>10 ❒8-10 ❒6-8 ❒<6

Do you feel rested upon awakening? ❒ Yes ❒ No What time of day are you most awake and alert? _____

STRESS

Do you feel you have an excessive amount of stress in your life? ❒ Yes ❒ No

Do you feel you have the ability to cope with the stress in your life? ❒ Yes ❒ No

Have you ever seen a psychotherapist? ❒Yes ❒ No Are you currently in counseling? ❒ Yes ❒ No

Do you practice meditation or relaxation techniques? ❒ Yes ❒ No

Check all that apply: ❒Yoga ❒Meditation ❒Tai Chi ❒QiGong ❒Imagery ❒Biofeedback ❒Prayer ❒Breath Work

RELATIONSHIPS

Marital Status: ❒Single ❒Married ❒Divorced ❒Gay/Lesbian ❒Long-term Partner ❒Widow

Children's Name (if any), Age and Gender

_____ _____

_____ _____

With whom do you live? List Name, Ages, Relationship

_____ _____

_____ _____

Who are the most important people in your life? List names and relationship

_____ _____

_____ _____

ENVIRONMENTAL

Do you have known adverse food reactions or sensitivities? ❒Yes ❒ No Describe _____

Do you have any food allergies or sensitivities? ❒Yes ❒ No Describe _____

Do you have an adverse reaction to caffeine? ❒Yes ❒ No When you drink caffeine to you feel ❒Irritable or Wired ❒Aches/Pains

Do you adversely react to: *Check all that apply*

❒Monosodium glutamate (MSG) ❒Aspartame (Nutrasweet) ❒Caffeine ❒Bananas ❒Garlic ❒Onion ❒Cheese

❒Citrus Foods ❒Chocolate ❒Alcohol ❒Red Wine ❒Sulfite-containing Foods (wine, dried fruit, salad bars)

❒Preservatives (ex. Sodium benzoate) ❒Other _____

Which of these significantly affect you? *Check all that apply*

❒Cigarette Smoke ❒Perfumes/ Colognes ❒Auto Exhaust Fumes ❒Other _____

In your work or home environment, are you exposed to: ❒Chemicals ❒Electromagnetic Radiation ❒Mold

Do you have a known history of significant exposure to any harmful chemicals such as: ❒Herbicides ❒Pesticides

❒Insecticides (frequent visits of exterminator) ❒Organic Solvents ❒Heavy Metals ❒Other _____

Chemical Name, Date, Length of Exposure _____

Do you dry clean your clothes frequently? ❒Yes ❒ No Do you have any or farm animals? ❒Yes ❒ No

Do you or have you lived or worked in a damp or moldy environment or had other mold exposures? ❒Yes ❒ No

Food Diary

Please list all food and beverages consumed in a 24-hour period. Include meals, snacks, beverages and condiments.

TIME	FOOD/ BEVERAGE	AMOUNT (CUP, OUNCES)

MSQ- MEDICAL SYMPTOM/TOXICITY QUESTIONNAIRE

The Toxicity and Symptom Screening Questionnaire identifies symptoms that help to identify the underlying causes of illness, and helps you track your progress over time. Rate each of the following symptoms based upon your health profile. If you are taking this questionnaire for the first time, record your symptoms for the last 48 hours ONLY. If this is a follow-up questionnaire, record your symptoms for the past 30 days.

POINT SCALE 0= Never or almost never have the symptom
1= Occasionally have it, effect is not severe
2= Occasionally have it, effect is severe
3= Frequently have it, effect is not severe
4= Frequently have it, effect is severe

DIGESTIVE TRACT
___Nausea or Vomiting
___Diarrhea
___ Constipation
___Bloated Feeling
___Belching or Passing Gas
___Heartburn
___Intestinal/Stomach Pain
*Total*____

EARS
___Itchy Ears
___Earaches, Ear Infections
___Drainage from Ear
___Ringing in Ears, Hearing Loss
*Total*____

EMOTIONS
___Mood Swings
___Anxiety, Fear or Nervousness
___Anger, Irritability, or Aggressiveness
___Depression
*Total*_____

ENERGY/ ACTIVITY
___Fatigue, Sluggishness
___Apathy, Lethargy
___Hyperactivity
___Restlessness
*Total*____

EYES
___ Watery or Itchy Eyes
___Swollen, Reddened or Sticky Eyelids
___Bags or Dark Circles under Eyes
___Blurred or Tunnel Vision (Does not include near- or far-sightedness
*Total*____

HEAD
___Headaches
___Faintness
___Dizziness
___Insomnia
*Total*____

HEART
___Irregular or Skipped Heartbeat
___Rapid or Pounding Heartbeat
___Chest Pain
*Total*____

JOINTS/MUSCLES
___Pain or Aches in Joints
___Arthritis
___Stiffness or Limitation of Movement
___Pain or Aches in Muscles
___Feeling of Weakness or Tiredness
*Total*____

LUNGS
___Chest Congestion
___Asthma, Bronchitis
___Shortness of Breath
___Difficult Breathing
*Total*____

MIND
___Poor Memory
___Confusion, Poor Comprehension
___Poor Concentration
___Poor Physical Coordination
___Difficulty in Making Decisions
___Stuttering or Stammering
___Slurred Speech
___Learning Disabilities
*Total*____

MOUTH/THROAT
___Chronic Coughing
___Gagging, Frequent Need to Clear Throat
___Sore Throat, Hoarseness, Loss of Voice
___Swollen/ Discolored Tongue, Gum, Lips
*Total*____

NOSE
___Stuffy Nose
___Sinus Problems
___Hay Fever
___Sneezing Attacks
___Excessive Mucus Formation
*Total*____

SKIN
___Acne
___Hives, Rashes or Dry Skin
___Hair Loss
___Flushing or Hot Flashes
___Excessive Sweating
*Total*____

WEIGHT
___Binge Eating/ Drinking
___Craving Certain Foods
___Excessive Weight
___Compulsive Eating
___Water Retention
___Underweight
*Total*____

OTHER
___Frequent Illness
___Frequent or Urgent Urination
___Genital Itch or Discharge
*Total*____

GRAND TOTAL _____

KEY TO QUESTIONNAIRE
Add individual scores and total each group. Add each group scores and give a grand total.
•Optimal is less than 10 •Mild Toxicity: 10-50 •Moderate Toxicity: 50-100 •Severe Toxicity: over 100

SYMPTOM REVIEW

Please check all current symptoms occurring in the past 6 months

GENERAL

- ❒Cold Hands & Feet
- ❒Cold Intolerance
- ❒Low Body Temperature
- ❒Low Blood Pressure
- ❒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 Pain
- ❒Ear Ringing/ Buzzing
- ❒Eye Crusting
- ❒Eye Pain
- ❒Hearing Loss
- ❒Hearing Problems
- ❒Headache
- ❒Migraine
- ❒Sensitivity to Loud Noises
- ❒Vision Problems (Other than glasses)

MUSCULOSKELETAL

- ❒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
- ❒Black-out
- ❒Depression

Difficulty:

- ❒Concentrating
- ❒With Balance
- ❒With Thinking
- ❒With Judgment
- ❒With Speech
- ❒With Memory

- ❒Dizziness (Spinning)
- ❒Fainting
- ❒Fearfulness
- ❒Irritability
- ❒Light-Headedness
- ❒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
- ❒Poor Appetite
- ❒Salt Cravings
- ❒Carbohydrate Craving (breads, pastas)
- ❒Sweet Cravings (Candy, Cookies, Cakes)
- ❒Chocolate Cravings
- ❒Caffeine Dependent

DIGESTION

- ❒Bad Teeth
- ❒Bleeding Gums

Bloating of:

- ❒Lower Abdomen
- ❒Whole Abdomen
- ❒Bloating after meals

- ❒Blood in Stools
- ❒Burping
- ❒Canker Sores
- ❒Cold Sores
- ❒Constipation
- ❒Cracking at Corner of Lips
- ❒Cramps
- ❒Dentures w/Poor Chewing
- ❒Diarrhea
- ❒Alternating Diarrhea & Constipation
- ❒Difficulty Swallowing
- ❒Dry Mouth
- ❒Excess Flatulence/ Gas
- ❒Fissures
- ❒Foods "Repeat" (Reflux)
- ❒Gas
- ❒Heartburn
- ❒Hemorrhoids
- ❒Indigestion
- ❒Nausea
- ❒Upper Abdominal Pain
- ❒Vomiting

Intolerance to:

- ❒Lactose
- ❒All Dairy Products
- ❒Wheat
- ❒Gluten (wheat, rye, barley)
- ❒Corn
- ❒Eggs
- ❒Fatty Foods
- ❒Yeast

- ❒Liver Disease/Jaundice
- ❒Abnormal Liver Function Tests
- ❒Lower Abdominal Pain
- ❒Mucus in Stools

SYMPTOM REVIEW *continued*

Please check all current symptoms occurring in the past 6 months

- ❒Periodontal Disease
- ❒Sore Tongue
- ❒Strong Stool Odor
- ❒Undigested Food in Stool

SKIN PROBLEMS

- ❒Acne on Back
- ❒Acne on Chest
- ❒Acne on Face
- ❒Acne on Shoulders
- ❒Athlete's Foot
- ❒Bumps on Back of Upper Arms
- ❒Cellulite
- ❒Dryness
- ❒Dark Circles Under Eyes
- ❒Ears Get Red
- ❒Easy Bruising
- ❒Lack of Sweating
- ❒Eczema
- ❒Hives
- ❒Jock Itch
- ❒Moles w/ Color/Size Change
- ❒Oily Skin
- ❒Rash
- ❒Red Face
- ❒Sensitive to Bites
- ❒Sensitivities to Poison Ivy/ Oak
- ❒Shingles
- ❒Skin Darkening
- ❒Strong Body Odor
- ❒Hair Loss
- ❒ Vitiligo

ITCHING SKIN

- ❒Skin in General
- ❒Anus
- ❒Arms
- ❒Ear Canals
- ❒Eyes
- ❒Feet
- ❒Hands
- ❒Legs
- ❒Nipples
- ❒Nose
- ❒Penis
- ❒Roof of Mouth
- ❒Scalp
- ❒Throat

LYMPH NODES

- ❒Enlarged/ Neck
- ❒Tender/ Neck
- ❒Other Enlarged/ Tender
- ❒Lymph Nodes

NAILS

- ❒Bitten
- ❒Brittle
- ❒Fungus/ Fingers
- ❒Fungus/ Toes
- ❒Pitting
- ❒Ridges
- ❒Soft
- ❒White Spots/ Lines

RESPIRATORY

- ❒Bad Breath
- ❒Cough
- ❒Hoarseness
- ❒Sore Throat

Hay Fever:

- ❒Spring
- ❒Summer
- ❒Fall
- ❒Change of Season

- ❒Nasal Stuffiness
- ❒Nose Bleeds
- ❒Post Nasal Drip
- ❒Sinus Fullness
- ❒Sinus Infection
- ❒Snoring
- ❒Wheezing
- ❒Winter Stuffiness

CARDIOVASCULAR

- ❒Angina/Chest Pain
- ❒Breathlessness
- ❒Heart Murmur
- ❒Irregular Pulse
- ❒Palpitations
- ❒Phlebitis
- ❒Swollen Ankles/ Feet
- ❒Varicose Veins

URINARY

- ❒Bed Wetting
- ❒Hesitancy (trouble starting)
- ❒Infection
- ❒Kidney Disease
- ❒Leaking/ Incontinence
- ❒Pain/Burning
- ❒Prostate Infections
- ❒Urgency

MALE REPRODUCTION

- ❒Discharge from Penis
- ❒Ejaculation Problem
- ❒Genital Pain
- ❒Impotence
- ❒Prostate or Urinary Infection
- ❒Lumps in Testicles
- ❒Poor Libido (sex drive)

FEMALE REPRODUCTION

- ❒Breast Cysts
- ❒Breast Lumps
- ❒Breast Tenderness
- ❒Ovarian Cyst
- ❒Poor Libido (sex drive)
- ❒Vaginal Discharge
- ❒Vaginal Odor
- ❒Vaginal Itch
- ❒Vaginal Pain with Sex

Premenstrual:

- ❒Bloating, Breast Tenderness
- ❒Carbohydrate Cravings
- ❒Chocolate Cravings
- ❒Constipation
- ❒Decreased Sleep
- ❒Diarrhea
- ❒Fatigue
- ❒Increased Sleep
- ❒Irritability

Menstrual:

- ❒Cramps
- ❒Heavy Periods
- ❒Irregular Periods
- ❒No Periods
- ❒Scanty Periods
- ❒Spotting Between Periods