

Smoke	Y N	Year started:	Packs per day:	Year stopped:
Alcohol	Y N	Year started:	How much:	Year stopped:
Street drugs	Y N	Type:	How often:	Year stopped:
Caffeine	Y N	Type:	How much:	How much:
Sleep problems	Y N	Type:	Type:	Type:
Exercise	Y N	Type:	How Often:	How often:
Cosmetics Y N	Perfumes Y N	Aftershaves Y N	Scented soaps Y N	

Do you have now or have you ever had any problems with any of the following?

1	HEAD, NECK	Y N
2	EYES, VISION	Y N
3	EARS, HEARING	Y N
4	TEETH	Y N
5	NOSE, MOUTH, VOICE	Y N
6	LUNGS, BREAST, CHEST	Y N
7	HEART	Y N
8	ARTERIES, VEINS	Y N
9	STOMACH, GALLBLADDER	Y N
10	LIVER, PANCREAS	Y N
11	BOWELS, RECTUM, HERNIA	Y N
12	KIDNEY, BLADDER	Y N

13	UTERUS, VAGINA	Y N
14	BACK, SHOULDER BLADES	Y N
15	RIBS, HIPS	Y N
16	ARMS, LEGS	Y N
17	NERVE, BRAIN DISEASE	Y N
18	SEIZURE, MIGRAINES	Y N
19	SKIN PROBLEMS	Y N
20	BLOOD DISEASES, SPLEEN	Y N
21	GLANDS, OBESITY	Y N
22	CANCER	Y N
23	PSYCHIATRIC PROBLEMS	Y N
24	PREGNANT	Y N
25	OTHER CONDITIONS	Y N

Explain Any "Yes" Answers:

Major Hospitalizations-List:

Heart Disease Risk Factors

Y N	Age Years - Male \geq 45 Female \geq 55 or early menopause without estrogen replacement therapy
Y N	Family history of premature Heart Disease (definite myocardial infarction or sudden death before 55 in father / close male relative, or 65 in mother / close female relative)
Y N	Current cigarette smoker
Y N	Hypertension (Blood pressure \geq 140/90 mm Hg confirmed by measurements on several occasions or taking antihypertensive medication)
Y N	Low HDL (good) cholesterol (<35 mg/dl confirmed by measurements on several occasions [0.9 mmo/L])
Y N	Diabetes mellitus (sugar)
Y N	High HDL (good) cholesterol (\geq 60 mg/dl [1.6 mmo/L])

Your Tests, Specify if known:

Your Tests, Specify if known:		Last Physical:	Xrays:	GI Series:
Gall bladder:	Kidney:	EKG:	Stress EKG:	Angiogram:
Ultrasound:	Blood Tests:	Others:		

Name: _____

Have you ever been on prolonged antibiotic therapy: Y N If Yes, what & why:

Have you traveled out of the country? Y N If yes, where & when?

Have you been treated for parasites? Y N Have you been tested for parasites? Y N

Do you do any stress reduction/relaxation such as meditation, yoga, self-hypnosis, etc.? Y N

What: How Often: Length of Sessions:

Your stress level: Low Moderate High

Sleeping Habits: Hours/Night: Restless or Restful What Time You Retire:

Wake During Night: Y N Dream: Y N

What are your hobbies or interests?

Immunizations, if Known:

Smallpox: Polio: Mumps: Pneumonia: Pertussis:

Tetanus: Flu: Measles: Diphtheria: Other:

Did your mother have any problems during her pregnancy with you (illness, stress, smoking, meds, alcohol)? Y N

Were you bottle or breast fed? Was your home life (circle): loving supportive stressful abusive peaceful

loud argumentative educational alcoholic friendly single-parent lonely or other—list

Childhood Illnesses (circle): colic eczema asthma polio allergies bronchitis pneumonia meningitis rheumatic fever recurrent colds

ear infections thrush German measles bedwetting tonsils out persistent diaper rash learning problems hyperactive or others—list

Family History	Living	Age	Health Problems**, Mental Illnesses or Cause of Death
Father	Y N		
Mother	Y N		
Brothers/Sisters	#		
Children	#		
			** Cancer, Thyroid, Hypertension, Heart Disease, Stroke, Diabetes, Aortic Aneurysm, Asthma

Other household members now living with you. Include family members, non-family members and pets.

Name	Relationship	Age	Occupation

Please indicate if you or any family members or grandparents, ever had any of the following problems—Specify

Alcoholism	Allergies
Arthritis	Asthma
Cancer	Epilepsy
Colitis/Crohn's Ds.	Diabetes
Herpes	Shingles
Drug Problems	Eczema
Heart Disease	High Blood Pressure

Please indicate if you or any family members or grandparents, ever had any of the following problems—Specify

Hepatitis	Frequent Infections
High Cholesterol	Bleeding/Bruising
Anemia	Low Blood Sugar
Digestive Disease	Weight Problems
Psoriasis	Urinary infections
Lupus	Mental Illness
Migranes	Pneumonia
Polio	Prostate Problems
Rheumatic Fever	Rheumatoid Disease
Sinus Disease	Strokes
Thyroid Problems	Tuberculosis
Ulcers	Venereal Disease

Comments/Explanations

Read carefully through the list of symptoms in each group, and put a check mark next to each symptom that you have. (If you check off the same symptom in more than one group, that's fine.)

SYMPTOM GROUP 1	Memory problems	Mood swings	Excessive Hair	Unstable blood sugar
PMS	Lethargic depression	Foggy Thinking	Polycystic ovaries	Thin and/or dry skin
Painful +/- or lumpy breasts	Night sweats	Gallbladder problems	Unstable blood sugar	Foggy thinking
Cyclical headaches	Bladder infections	Weight gain	Infertility	Brown spots on face
Insomnia	Painful intercourse	Migranes	Thinning hair on head	Total Checked
Weight gain	Hot flashes	Insomnia	Ovarian cysts	
Infertility	Total Checked		Brown spots on face	
Early miscarriage	SYMPTOM GROUP 3	Total Checked	Total Checked	
Anxiety	Puffiness/Bloating	SYMPTOM GROUP 4	SYMPTOM GROUP 6	
Total Checked	Heavy bleeding	Total of Grps 1 & 3	Debilitating fatigue	
SYMPTOM GROUP 2	Anxious depression	SYMPTOM GROUP 5	Low blood pressure	
Vaginal dryness	Breast Tender	Acne	Intolerance to exercise	

Date of last pap smear: _____ Was it normal? Y N If no, explain: _____

Have you ever had an abnormal pap smear? Y N What was found? _____ How treated? _____

Date of last mammogram? _____ Was it normal? Y N If no, explain: _____

Date last stools checked for blood: _____ Was it normal? Y N If no, explain: _____

Date of last sigmoidoscopy or colonoscopy? _____ Was it normal? Y N If no, explain: _____

Do you do breast self exams? Y N How often? _____

Pregnancies—Number: _____ Dates/Outcomes: _____

Have you breast fed? Y N When & how long? _____

Do you use birth control? Y N What methods & how long? _____

Are you in menopause? Y N Do you still spot or bleed? Y N Describe: _____

Are you post-menopausal? Y N If yes, when did you go through menopause? _____

Name: _____

Please discuss any gynecological complaints:

1	Breast lumps	Y	N
2	Fibrocystic breast disease	Y	N
3	Nipple discharge	Y	N
4	Breast Operations	Y	N
5	Pelvic Inflammatory disease	Y	N
6	Endometriosis	Y	N
7	Fibroids	Y	N
8	Ovarian cysts	Y	N
9	Fertility problems	Y	N
10	Lower abdominal pain	Y	N
11	Pressure in vagina	Y	N

12	Pain with intercourse	Y	N
13	Change in sex drive or pleasure	Y	N
14	Frequent urination	Y	N
15	Bladder infections	Y	N
16	Genital herpes	Y	N
17	Venereal warts	Y	N
18	Vaginal yeast infections	Y	N
19	Any venereal disease	Y	N
20	Vaginal itching or burning	Y	N
21	Undiagnosed vaginal discharge	Y	N

Explain Any "Yes" Answers:

Menstrual Cycle Symptoms		P—Prior D—During A—After
1	Intermittent cramps	P D A
2	Constant cramps	P D A
3	Low back pain	P D A
4	Pressure sensations	P D A
5	Headaches	P D A
6	Sugar cravings	P D A
7	Depression	P D A
8	Irritability	P D A
9	Breast Tender	P D A
10	Acne	P D A
11	Mood swings	P D A
How severe are the symptoms?		
What treatments have you tried?		

Menstrual Cycle Information	
Your age at your first period:	
Dates of last 2 periods: 1: 2:	
Length of cycles: Is it irregular? Y N How?	
Do you spot in between? Y N How many days of bleeding?	
Number of pads or tampons: Type of pad or tampon:	
Do you pass clots? Y N Do you use hygiene products? Y N	
Type of underwear?	

Living Environment—circle: Urban Suburban Country Seaside Lakeside

Type of Heat: Humidifier: Y N Wood Stove: Y N Type of Insulation:

Is the Cellar: Dry Damp Musty Dusty Is the House: Old New Has it been treated for pests? Y N What Kind?

Do you use feather or down covers, comforters or jackets? Y N Do you have an air filter or cleaner? Y N

Are there animals at home or places you visit frequently? Y N What kind:

Do you use strong chemical cleaners, solvents, paints, etc.? Y N What?

Fill in “C” for current problem; “I” for an intermittent problem; “P” for a past problem

_____ Headaches	_____ High blood pressure	_____ Weakness
_____ Neck lumps or swelling	_____ Skipped heartbeats	_____ Painful feet
_____ Loss of balance	_____ Racing heart	_____ Leg cramps
_____ Dizzy spells	_____ Chest pain or pressure	_____ Trembling or tremors
_____ Vertigo	_____ Swollen feet or ankles	_____ Seizures or epilepsy
_____ Blackouts or fainting	_____ Difficulty breathing at night	_____ Numbness or tingling
_____ Blurry vision	_____ Varicose veins or phlebitis	_____ Skin tumors
_____ Double vision	_____ Recurring indigestion	_____ Dry skin
_____ Cataracts	_____ Nausea or vomiting	_____ Acne
_____ Eye pain or itching	_____ Intestinal gas/ flatulence	_____ Eczema
_____ Watering eyes or redness	_____ Belching	_____ Skin rashes
_____ Hearing difficulties	_____ Bloating	_____ Psoriasis
_____ Earaches or drainage	_____ Abdominal pain or cramps	_____ Dandruff or seborrhea
_____ Noises or ringing in ears	_____ Constipation	_____ Hives
_____ Recurrent ear infections	_____ Diarrhea or loose stools	_____ Itching or burning skin
_____ Dental problems/ decay	_____ Rectal itching	_____ Easy bruising
_____ Sore or bleeding gums	_____ Blood with stools	_____ Hypothyroid (low)
_____ Sore tongue	_____ Black stools	_____ Hyperthyroid (high)
_____ Coated tongue	_____ Pain in rectum	_____ Weight gain
_____ Loss of taste or smell	_____ Jaundice	_____ Weight loss
_____ Sores in or around mouth	_____ Hepatitis/pancreatitis	_____ Feel excessively warm
_____ Difficulty swallowing	_____ Colitis	_____ Feel excessively cold
_____ Cold sores or blisters	_____ Crohn's disease	_____ Loss of appetite
_____ Sinus or nasal congestion	_____ Diverticulitis/diverticulosis	_____ Constant hunger
_____ Runny nose	_____ Frequent urination	_____ Fatigue or weariness
_____ Frequent colds	_____ Brown or red urine	_____ Night sweats
_____ Nasal polyps	_____ Decreased force of urine	_____ Diabetes
_____ Sore throats	_____ Continual urge to urinate	_____ Low blood pressure
_____ Swollen glands	_____ Difficulty starting urination	_____ Nervousness or anxiety
_____ Recurrent fevers or chills	_____ Kidney or bladder infection	_____ Depression
_____ Hoarse voice	_____ Involuntary escape of urine	_____ Suicidal thoughts
_____ Shortness of breath	_____ Venereal disease	_____ Sought psychological help
_____ Wheezing or gasping	_____ Aching muscles or joints	_____ -MEN ONLY-
_____ Coughing	_____ arthritis	_____ Painful testicles
_____ Coughing blood	_____ Joint stiffness	_____ Hernia
_____ Chest colds or pneumonia	_____ Back or neck pain	_____ Prostate problems
_____ Heart murmur	_____ Osteoporosis	_____ Sexual dysfunction

Name: _____

Fill in the number that best describes your feelings most recently.

0 = not at all; 1 = a little bit; 2 = moderately; 3 = quite a bit; 4 = extremely

- | | |
|--|--|
| _____ Nervousness or shakiness inside | _____ Your mind is in a fog |
| _____ Repeated unpleasant thoughts | _____ Having a lump in your throat |
| _____ Loss of sexual interest or pressure | _____ Feeling tense or keyed up |
| _____ Feeling exuberant or enthusiastic | _____ Heavy feeling in your arms or legs |
| _____ The idea that others can control your thoughts | _____ Thoughts of death or dying |
| _____ Feeling others are to blame for your troubles | _____ Feeling uneasy when people are watching you |
| _____ Trouble remembering things | _____ Having to repeat the same actions over and over |
| _____ Feeling afraid in open spaces or outside | _____ Having urges to break or smash things |
| _____ Feeling critical of others | _____ Feeling self-conscious with others |
| _____ Feeling that your goals and aims are clear in life | _____ Having a good sense of humor |
| _____ Thoughts of ending your life | _____ Feeling everything is an effort |
| _____ Hearing voices that others do not hear | _____ Spells of panic or terror |
| _____ Feeling easily annoyed or irritated | _____ Getting into frequent arguments |
| _____ Crying easily | _____ Feeling relaxed |
| _____ Feeling happy and lighthearted | _____ Feeling nervous when you are left alone |
| _____ Feeling shy or uneasy with the opposite sex | _____ Feeling that others do not give you proper credit for your achievements |
| _____ Feeling of being trapped or caught | _____ Feeling your life is filled with good things |
| _____ Temper outbursts that you cannot control | _____ Feeling lonely even when you are with people |
| _____ Blaming yourself for things | _____ Never feeling close to another person |
| _____ Feeling blocked in getting things done | _____ Feeling at peace with your surroundings |
| _____ Feeling in control of your life | _____ Feelings of guilt |
| _____ Feeling lonely | _____ Having the idea that something is wrong with your mind |
| _____ Feeling blue or depressed | _____ Feeling very responsible for others |
| _____ Facing daily tasks is a source of pleasure | _____ Feeling able to turn to your family for help when something is troubling you |
| _____ Worrying too much about things | _____ Feeling satisfied with your family's affection and responses to your emotional needs |
| _____ Feeling no interest in things | _____ Feeling harmony in your personal world |
| _____ Feeling fearful or afraid | _____ Feeling angry |
| _____ Your feelings are hurt easily | _____ Feeling that your ability to find meaning in life is very great |
| _____ Others are aware of your private thoughts | _____ Being a responsible person |
| _____ Others do not understand you | _____ Feeling good about your personal relationships |
| _____ Must do things very slowly to insure correctness | _____ Feeling afraid to travel by bus, train, or in cars |
| _____ Feeling watched or talked about by others | _____ Feeling your personal existence is valuable |
| _____ Difficulty making decisions | |

This index indicates degrees of stress related to changes in life. In studies, many people who scored over 300 became ill within a 3 to 6 month period. If an event has been true for you in the past year, or is about to happen, circle the associated point value. If an unlisted event has occurred, add it to the bottom of the list and assign it a point value. Add up the points.

Death of spouse or partner	100
Divorce	73
Separation from spouse or partner	65
Jail term	63
Death of a close family member	63
Personal injury or illness	53
Marriage/commitment to a partner	50
Fired at work	47
Reconciliation with a spouse/partner	45
Retirement	45
Change in health of family member	44
Pregnancy	40
Sex difficulties	39
Addition of new family member	39
Business readjustment	39
Change in financial state	38
Death of a close friend	37
Change to a different line of work	36
More arguments with spouse/partner	35
Mortgage over 50,000	31
Foreclosure of mortgage or loan	30
Change in work responsibilities	29
Child leaving home	29
Trouble with in-laws	29
Outstanding personal achievements	28
Spouse/partner begins/stops work	26
Begin or end school	26
Change in living conditions	25
Revision of personal habits	24
Trouble with boss or employee	23
Change in work hours or conditions	20
Change in residence	20
Change in schools	20
Change in recreation	19
Change in church activities	19
Change in social activities	18
Mortgage or loan under 50,000	17
Change in sleeping habits	16
Change in eating habits	15
Vacation	13
Christmas approaching	12
Minor violations of the law	11
Other	
Other	
TOTAL OF ALL POINTS	<input type="text"/>

Specify what foods and beverages you normally consume during a typical day.

Weekdays

Breakfast

Snack

Lunch

Snack

Dinner

Snack

Weekends

Breakfast

Snack

Lunch

Snack

Dinner

Snack

Do you binge? Y N Use foods for reward or escape? Y N

If so, what foods or beverages do you use, and how often?

What foods would be most difficult to give up?

Do you have specific food cravings? Y N What Foods?

What work or scheduling considerations might create difficulties for you trying to change your eating or any other health habits?

List any known food allergies:

Name: _____

Please check the following boxes according to the frequency of your personal habits.

Frequent = at least once per day; **Often** = several times per week; **Occasional** = once per week or less;
Seldom = once or twice per month or less; **Never** = almost total avoidance

Frequent	Often	Occasional	Seldom	Never	
					1. Alcoholic beverages
					2. Eat at restaurants
					3. Eat at fast food restaurants
					4. Pastries, cookies, candies, ice cream, other sweets
					5. Add sugar to coffee, tea, cereals or other foods
					6. Colas or other soft drinks
					7. Instant breakfasts, pop tarts, doughnuts, muffins
					8. Cold breakfast cereals
					9. Caffeine drinks (coffee, tea, cola, chocolate)
					10. Deep fried foods
					11. Margarine of any type
					12. Whole grain hot cereals (oatmeal, wheatena, etc.)
					13. Meat (beef or veal, pork or ham, liver ,lamb)
					14. Chicken or turkey -circle : regular or free range
					15. Fresh fish
					16. Processed meat (bologna, turkey roll, sausage, etc.)
					17. Fresh raw fruit
					18. Fresh vegetables, raw or cooked
					19. Salads
					20. Whole grains or whole grain breads
					21. White bread or white flour products
					22. Beans and legumes (lentil, kidney, chickpea, etc.)
					23. Yogurt– circle: whole or low-fat, plain or flavored
					24. Milk– circle: whole or low- fat or skimmed
					25. Cheese
					26. Eggs– circle: regular or free range
					27. Salt
					28. Herbs, fresh and dried, or spices
					29. Drink adequate water—circle: tap, filtered, or bottled
					30. Eat excessively if bored or depressed
					31. Swallow food before chewing well
					32. Hurried or rushed meals
					33. Stuff yourself
					34. Read and understand food labels
					35. Sneak or hide foods
					36. Adequate fiber or roughage in the diet
					37. Artificial sweeteners (saccharin, Nutrasweet, etc.)
					38. Shop at health food stores

DO NOT PASTE OR ATTACH LABELS

INGREDIENT	AMOUNT IN MULTIPLE VITAMIN-MINERAL	AMOUNT IN INDIVIDUAL SUPPLEMENTS	DAILY TOTAL
Vitamin A			
Beta-Carotene			
Vitamin B1 (Thiamine)			
Vitamin B2 (Riboflavin)			
Vitamin B3 (Niacin)			
Vitamin B3 (Niacinamide)			
Vitamin B5 (Pantothenic Acid)			
Vitamin B6 (Pyridoxine)			
Vitamin B12 (Cobalmin)			
Vitamin C			
Vitamin D			
Vitamin E			
Vitamin K			
Biotin			
Folic Acid			
Choline			
Inositol			
Bioflavonoids			
Boron			
Calcium			
Chromium			
Copper			
Iodine			
Iron			
Magnesium			
Manganese			
Molybdenum			
Phosphorus			
Potassium			
Selenium			
Silica			
Zinc			

