Patient Name: ___________________________________ Date:___________________________

This form will become part of your medical record and the contents are confidential. It is very important to answer all questions as this will be most helpful in evaluating your condition. Please answer the questions by checking the appropriate space (Yes or No where appropriate)

Occupation: _______________________________ Hobbies: ________________________________

List Work and History Dates: __________________ ____

List all provinces, states, and countries in which you have lived: ______________________________
____ ____
____ ____

Reason/Goal for your visit and treatment: ____
____
____

How did you hear about our clinic? ____

General Health Information: Height: ___ Weight:___ BP(when last taken): ___
When and where did you get your last physical check-up? ___________________________________
____

Chief Complaint and Present Illness
Major area of concern (single worst): ____
____

List other areas of concern in order of severity:
1. ____ 2. ____
3. ____ 4. ____
5. ____ 6. ____
7. ____ 8. ____

Date or age main symptom first began? ____
Began in what state or country? ____
Please complete if relevant. If not applicable, go to section 2.

When and where did latest episode begin and end? ____
How often do episodes occur? O Daily O Weekly or ___ Times/month
How long do they last? O Minute O Hours ___ Days or ___Weeks

What symptoms, if any remain in between attacks? (list in order of severity)
1. ____
2. ____
3. ____

Never free of symptoms? O Yes O No
Free of symptoms? O Yes O No
When?________________________

Symptoms worse what time of the day?
O Awakening O Afternoon O Evening O Night O No pattern

Symptoms relieved by medication? Which medication?
____
O Slightly O Moderately O Completely O Not at all

Symptoms associated with fever or signs of infections? O Frequently O Never
Symptoms are worse after lights have been on an hour? O Yes O No

Early Spring? O Yes O No In June? O Yes O No
In September O Yes O No

MEDICAL HISTORY:
Name any conditions such as kidney trouble, diabetes, heart disease, stroke, loss of consciousness etc., which you presently have or have had: ____
____
____
____
____
____
____
____
____

Have you had a birth defect? O Yes O No
If yes, explain____________________
Have you had a birth injury? O Yes O No
If yes, explain____________________

Immunization: Have you ever had:
Please include ***reactions*** if any:

Smallpox vaccination?	O Yes	O No	If yes, when? ___________________
DPT or tetanus toxoid?	O Yes	O No	If yes, when? ___________________
Polio immunization?	O Yes	O No	If yes, when? ___________________
Measles/Mumps/Rubella?	O Yes	O No	If yes, when? ___________________
Flu vaccine?	O Yes	O No	If yes, when? ___________________
HPV vaccine?	O Yes	O No	If yes, when? ___________________
Hep A/B vaccine?	O Yes	O No	If yes, when? ___________________
Pneumococcal vaccine?	O Yes	O No	If yes, when? ___________________

Other:____

List medications you are presently taking including dosage:
____ ____
____ ____
____ ____
____ ____
____ ____
____ ____

List supplements and remedies (non-pharmaceuticals i.e. Herbs, homeopathics, vitamins/minerals) you are presently taking (include brand):

____ ____
____ ____
____ ____
____ ____
____ ____
____ ____
____ ____

List medications and supplements you have taken in the past:

____ ____
____ ____
____ ____

Hospitalization:

Please list all hospitalizations and state purpose: ____
____
____

Please list all operations and give dates: ____
____
____
____

COMMUNICABLE DISEASE: Check items which apply:

Do you now or have you ever had?

Measles	O Yes O No	Rheumatic fever	O Yes O No
German measles	O Yes O No	Polio or meningitis	O Yes O No
Mumps	O Yes O No	Tuberculosis	O Yes O No
Chicken pox	O Yes O No	Valley fever	O Yes O No
Whooping cough	O Yes O No	Infectious mononucleosis	O Yes O No
Diptheria	O Yes O No	Syphilis	O Yes O No
Influenza	O Yes O No	Gonorrhea	O Yes O No
Scarlet fever	O Yes O No	Other: ______________________________	

Studies: Check items which apply:

In the past 10 years have you had any of the following studies:

	Yes	No	If yes, when?
X-rays of the sinuses			
X-rays of the chest			
X-rays of the stomach, gallbladder or colon			
X-rays of the teeth (dental examination)			
Scans of the whole body, bone, or brain			
Electrocardiogram			
Hearing tests			
Blood or urine tests			
Tuberculin skin test (TB skin test)			
Prostate examination			
Mammography			

SENSITIVITY ANALYSES

Contact Dermatitis: Check items which apply:

Has your skin ever been bothered by contact with any substances? ○ Yes ○ No

If yes, please specify: ____

How widespread was the involvement? ____

How frequently has it recurred? ____

What treatment have you used? ____

Have you ever had?

○ Poison oak ○ Poison Ivy ○ Poison sumac ○ Other_________

Does wearing metal watches, rings, necklaces cause you to "break out"? _______________________

Insect Sensitivity:

List any insect bite or sting you get that causes greater than normal reaction:___________________

Check any reactions you get:

○ Hives ○ Fainting ○ Nausea
○ Dizziness ○ Shock ○ Loss of consciousness
○ Vomiting ○ Mental confusion ○ Large local swelling
○ Difficulty breathing ○ Difficulty swallowing ○ Other:_____________________
○ Required hospitalization ○ Anaphylaxis

Do insects seem to single you out? ○ Yes ○ No Which insects?____________

How many reactions to insects have you had?____

What type of treatment do you receive after each reaction? _________________________________

TREATMENT

Allergy: Check items which apply

Have you ever had allergy tests? ○ Yes ○ No

If yes, when and what type? ____

____

With which physician?____

Are you taking allergy injections at the present time? ○ Yes ○ No

If yes, please explain.____

Do you frequently require emergency treatment for allergy? ○ Yes ○ No

How many times per year? ____

List current allergy treatment, if any: ____

FAMILY HISTORY: Check any of the following illnesses which occurred in your family (blood relative):

	Yes	No	If yes, who?
Migraine			
Hayfever, sinus trouble, or frequent colds			
Asthma, bronchitis or frequent colds			
Hives			
Eczema			
Skin rash from cosmetics, metals, or detergents			
Poison ivy or oak, ultraspore, sumac			
Insect allergy			
Food allergy			
Allergy towards drugs, pills, injections, or immunizations			
Headache			
Vertigo			
Epilepsy			
High blood pressure			
Low blood pressure			
Heart attack			
Heart disease			
Stroke			
Vascular disease			
Blood disease like leukemia, severe anemia, bleeding tendency			
Brain tumours			
Tuberculosis			
Emphysema			
Kidney disease			
Constipation			
Indigestion			
Diarrhea			
Diabetes			
Arthritis			
Undue fatigue			
Cancer			
Psychiatric care			
Depression			
Nervousness			
Nervous breakdown			
Emotional problems			
Drug use			
Other			

Explain:____
____

	Present Age	Major illness if any	Age at Death	Cause
Father				
Mother				
Brother				
Sister				
Son(s)				
Daughter(s)				
Maternal grandmother				
Maternal grandfather				
Paternal grandmother				
Paternal grandfather				

Review of Symptoms

SKIN, HAIR, NAILS: Check past or current skin symptoms

- O Eczema
- O Redness
- O Rash
- O Dryness
- O Oiliness
- O Lumps
- O Petechia
- O Dry hair
- O Scaly lesions
- O Itching
- O Edema (swelling)
- O Cracking
- O Acne
- O Boils
- O Bruise easily
- O Falling/thinning hair
- O Weeping lesions
- O Hives
- O Blanching
- O Peeling
- O Shingles
- O Foot odours
- O Fungus of nails

List the main skin areas involved: ____

Is your skin sensitive to: O Sun O Fabrics O Detergents O Other:________

Did you have unusually severe acne? O Yes O No

Antibiotics given: O Yes O No How long: __________Type:_____________________

HEADACHE: Check the items which apply to pain and intensity:

- O Constant
- O Vice-like
- O Pulsating
- O Dull
- O Heaviness
- O Pressure
- O Throbbing
- O Excruciating
- O Tight
- O Burning
- O Soreness
- O Cramp-like
- O Constriction
- O Episodic
- O Drawing
- O Band-like
- O Cutting
- O Acute

Check the location(s) of head pain and associated symptoms:

- O On the right side of head
- O On the back of neck
- O Back of eyes
- O In upper teeth
- O Top of head
- O Back of head
- O Forehead
- O Temple
- O On the left side of head
- O On the crown of head
- O In the cheek
- O Begins slowly
- O Lasts hours
- O Returns regularly
- O Clears without treatment
- O Clears with treatment
- O Lasts seconds
- O Lasts minutes
- O Lasts days
- O Begins suddenly
- O Episodic
- O Relieved by walking

Review of Systems Cont.

Check items associated with headache:

- O Loss of sight
- O Dazzling lights
- O Diarrhea
- O Swelling of eye
- O Inflamed eye
- O Tearing of eye
- O Vertigo
- O Running nose
- O Nasal blockage
- O Visual disturbance
- O Pallor
- O Queasy stomach
- O Abdominal pain
- O Nausea
- O Vomiting
- O Neck/shoulder pain
- O Flushing
- O Chilly sensation
- O Dizziness

Check what your headache is preceded or worsened by:

- O Exercise
- O Odors
- O Alcoholic drinks
- O Arguments
- O Foods
- O Coffee/tea
- O Muscle strain
- O Unusual stimulation
- O Fear
- O Anger
- O Fasting
- O Disappointment
- O Intense light
- O Eye strain
- O Chilling
- O Intense thinking
- O Humidity
- O Overheating
- O Anxiety
- O Rejection
- O Infections
- O Motion
- O Noise
- O

Other:________________________

EYES: Check symptoms which apply:

- O Itching
- O Dryness
- O Styes
- O Puffiness
- O Bloodshot
- O Dark circles
- O Cataracts
- O Wear contacts
- O Irritated
- O Burning
- O Crusty lids
- O Twitching lids
- O ”floaters”
- O Blurred vision
- O Glaucoma
- O Near-sighted
- O Watering
- O Pain
- O Granulated lids
- O Swelling of lids
- O Mucus in eyes
- O Sensitive to light
- O Wear glasses
- O Far-sighted

EARS: Check symptoms which apply:

- O Hearing loss
- O Itching inside
- O Floating sensation
- O Pressure
- O Serous otitis
- O Tubes in ears
- O Nerve deafness
- O Crusting inside
- O Dizziness
- O Pain
- O Frequent infections
- O Plugged ears
- O Wear hearing aid
- O Ringing/roaring
- O Sense of imbalance
- O Fluid accumulation
- O Drainage

Are these symptoms present all year round? O Yes O No

Which is your worst season? O Spring O Summer O Fall O Winter

Which months? ____

NOSE/SINUS: Check each symptom which applies (to greater than normal degrees):

- O Itches
- O Sneezes
- O Burns
- O Post nasal drip
- O No sense of smell
- O Blocks
- O Bleeds
- O Blisters
- O Mucus yellow
- O Polyps
- O Runs
- O Crusts
- O Sinus infections
- O Mucus blood-streaked
- O Require nose drops/spray
- O Other ___________________________________

Review of Systems Cont.

Are these symptoms present all year round? O Yes O No

Which is your worst season? O Spring O Summer O Fall O Winter

Which months? ____

When? O Upon rising O After meals O After medicines
O Upon lying down O At night O Cold
O Hot O Dry O

Other:______________________

MOUTH AND THROAT: Check symptoms that apply:

O Cracked lips/corners	O Chapped lips	O Fever blisters
O Sleep with mouth open	O Hoarseness	O Tongue swollen
O Sore/raw tongue	O Lose voice	O Sore throats
O Throat/palate itch	O Difficulty swallowing	O Teeth pain
O Throat clearing	O Throat closes	O Fillings, which type?___________
O Neck glands swell	O Post nasal drip	O Bad taste
O Wear dentures	O Grind teeth in sleep	O Bad breath
O Gum problems	O Cankers	

If you use any of the following, indicate the brand name:

______Toothpaste	______Adhesive for dental plates	______Lipstick
______Tobacco	______Mouthwash	______Chewing gum
______Chapstick	______Cough drops	______Teeth Whitener

Do you have any root canals? O Yes O No Which teeth?_____________________

Do you have amalgam fillings? O Yes O No

HEART: Check any of these symptom that you have now or have had in the past:

O Racing heart rate	O Skipped beats	O Murmurs
O Enlargement	O Chest pains	O Angina
O Ankle swelling	O Tingling	O Flushing
O High blood pressure	O Blue lips	O Rheumatic fever

Circulation

O Deep leg pain	O Cold hands/feet	O Varicose veins
O Ulcers	O Leg cramps	O Numbness

Which is your main symptom? ____

When is this symptom worse?

O Morning	O Spring	O Year round
O Mid to late morning	O Summer	O Other:_____________________
O Mid to late afternoon	O Fall	
O Night	O Winter	

Which medications relieve you best? ____

How soon do these medications relieve you? ______________________________________

For how long do these medications relieve you? ___________________________________

Do you smoke? O Yes O No

How many per day?___ How long have you smoked?_________________________________

Review of Systems Cont.

Have you ever smoked? O Yes O No How long did you smoke?_____________________________

When did you quit? ____

RESPIRATORY: Check any symptom you have now or have had in the past?

O Wheezing	O Asthma	O Bronchitis
O Frequent colds	O Frequent infections	O Pneumonia
O Frequent coughs	O Pleurisy	O Night sweats
O Croup	O Tight chest	O Heavy chest
O Cough - mucus	O Emphysema	O Short of breath
O Cough – dry		

How far can you walk vigorously before becoming short of breath?_____________________________

Which is your main symptom? ____

When is this symptom worse?

O Morning	O Spring	O Year round
O Mid to late morning	O Summer	O Other:______________________
O Mid to late afternoon	O Fall	
O Night	O Winter	

GASTROINTESTINAL: Check symptoms which apply:

O Heartburn	O Indigestion	O Re-taste food
O Bloating	O Flatulence	O Belch frequently
O Good appetite	O Queasy stomach	O Bloody stools
O Poor appetite	O Frequent nausea	O Stomach aches
O Picky eater	O Frequent vomiting	O Constipated
O Cramping	O Vomit blood	O Anal itching
O Use laxatives	O Diarrhea	O Tarry stools
O Ulcer	O Anal pain	O Rectal bleeding
O Mucus in stools	O Gallbladder trouble	O Hemorrhoids

How often do you have bowel movements? ____

GENITOURINARY: Check items which apply:

O Kidney disease	O Kidney stones	O Difficult urination
O Prostate trouble	O Painful urination	O Sores
O Bladder disease	O Incontinent	O Have discharge
O Itching	O Burning	O Bedwetting
O Increased urinary frequency	O Hesitancy	O Blood in urine

MUSCULOSKELETAL: Check which items apply:

Do you have: muscle pain? O Yes O No How severe (scale 1-10; 10=severe)___

Joint swelling/pain? O Yes O No How severe (scale 1-10; 10=severe)___

Has fluid been removed? O Yes O No When?______________________________

Have you ever had any broken bones?

O Yes O No Which bone(s)?_____________________

Review of Systems Cont.

Check if you have the symptoms below. Please indicate **R** for right side or **L** for left side.

___Morning stiffness
___Pain in elbows
___Pain in shoulder
___Tingling in hands and fingers
___Numbness in fingers
___Loss of strength in hand
___Always dropping objects
___Left side turning cold
___Right side turning cold
___Fingers and hands turn cold
___Cold feet
___Colour change
___Blue ___Red ___Blanching
___Other:____
___Cramping in legs when walking
___Cramping in legs when resting
___Limitation of movement in legs
___Limitation in moving arm

NEUROLOGICAL: Check items which apply:

- O Weakness in limb
- O Numbness
- O Tingling
- O Abnormal walking pattern
- O Tremor
- O Convulsions
- O Blurred vision
- O Double vision
- O Foot drop
- O Spinal pain
- O Neck pain
- O Back pain
- O Abnormal EEG
- O Diagnosis of MS
- O Lack of coordination
- O Tics
- O Seizure

HORMONES: Check items which apply:
Do you have or have you ever had:

Weight loss of more than five pounds during the last 12 months O Yes O No
Weight gain of more than five pounds during the last 12 months O Yes O No

- O Lack of appetite
- O Abnormal thirst
- O Enlarged thyroid
- O Hypoglycemia
- O Notable increase in appetite
- O Diabetes or sugar in the urine
- O Overactive thyroid
- O Weight gain/swelling Of any part
- O Underactive thyroid
- O Cramps in legs

MEN ONLY: Check which items apply:

- O Prostate problems
- O Impotency
- O Urinary dribbling
- O Split-stream urine
- O Hernias
- O Discharge/sores
- O Loss of sexual desire
- O Difficulty attaining an erection
- O Difficulty maintaining an erection
- O Mood changes
- O Venereal disease
- O

Other:___________________________________

WOMEN ONLY: Check which items apply:

- O Breast soreness before periods
- O Breast soreness during periods
- O Had breast biopsy
- O Breast implants
- O Vaginal itching
- O Venereal disease
- O Breast cysts or lumps
- O Breast soreness
- O Had mastectomy
- O Vaginal discharge
- O Pain during intercourse
- O Other:__________________________

Age of onset of menses? ____
Last menstrual period date? ____

Review of Systems Cont.

- O Regular periods
- O Irregular periods
- O Scant flow
- O Heavy flow
- O Partial/total hysterectomy
- O Had D & C
- O Had miscarriage
- O Use lubricants
- O Use diaphragm
- O Use contraceptive pill
- O Use foam
- O Use douches
- O Pregnant now

Do you have symptoms before periods? ____
How long do they last? ____

Do you have symptoms during periods?____
How long do they last? ____

Do you have symptoms at ovulation?____
How long do they last? ____

Last PAP smear? ____

Breasts

Do you do self breast examinations?	O Yes	O No
Any lumps?	O Yes	O No
Pain or tenderness?	O Yes	O No
Nipple discharge?	O Yes	O No

Age at menopause? ___ Are you taking hormones? Which one(s)?_______________________

Surgery of uterus, ovaries etc.?	O Yes	O No	___Year
D & C?	O Yes	O No	___Year
Cesareans?	O Yes	O No	___Year
Breast surgery?	O Yes	O No	___Year
Mastectomy?	O Yes	O No	___Year
Breast implants?	O Yes	O No	___Year

How many pregnancies? _______ How many live births? _______
How many premature births? _______ How many stillbirths? _______
How many miscarriages? _______
Any complications with pregnancies? O Yes O No
If yes, please specify and state when? ____
____
Any adopted children? O Yes O No

PSYCHOLOGICAL: Check items which apply:

- O Feel groggy
- O Short attention span
- O Unable to reason
- O Unable to concentrate
- O Forgetful
- O Startled by sudden noises
- O Shaky
- O Considered a nervous person
- O Frequently keyed up/jittery
- O Fainting spells
- O Blackouts
- O Worried by little things
- O Sweats with anxiety
- O Frustration
- O Psychiatric care
- O Amnesia
- O Had shock therapy
- O Go to pieces easily
- O Often break out in cold sweats
- O Profuse Sweating
- O Cry often
- O Feel insecure
- O Pale
- O Restless legs
- O Considered clumsy
- O Unable to coordinate muscles
- O Have difficulty falling asleep

Review of Systems Cont.

- O State of anxiety
- O Numbness
- O Have difficulty staying asleep
- O Unusual tension
- O Listless
- O Have difficulty staying awake
- O Often feel suddenly scared
- O Withdrawn feeling
- O Sleep walking
- O Feel "lost" in time
- O Had a nervous breakdown
- O Hyperactive
- O Often awakened by frightening dreams
- O Use tranquilizers
- O Family member had nervous breakdown
- O Am a workaholic
- O Hospitalized for nerves
- O Misunderstood by others
- O Often unable to work
- O Aggressive
- O Often unhappy
- O Extremely shy or sensitive
- O Have had hallucinations
- O Irritable
- O Have had visions
- O Easily flare in anger
- O Feeling of hostility
- O Have heard voices
- O Am being controlled by other forces
- O Have overused alcohol
- O Have overused drugs
- O been addicted to a drug
- O Has seriously considered suicide
- O Other: ____

Exactly what do you do in your occupation or daily life? ____
____

LIFESTYLE HISTORY:

I drink daily: coffee ____ decaff coffee ____ alcohol ____ soft drinks ____
Water ____ Herbal tea ____ milk____ juice ____

Amount of tobacco consumed? ____ per day

Do you use any recreational drugs? O Yes O No

If yes, which type(s) and how often? ____

Do you exercise regularly? O Yes O No

Type and duration: ____

Do you use a relaxation technique? O Yes O No

Type and how often?____

Sleep

How many hours of sleep do you get? ____

Do you wake up rested? O Yes O No

Do you wake in the middle of the night? O Yes O No What time?______________

Do you recall dreaming? O Yes O No

Do you have recurrent dreams? O Yes O No

ENVIRONMENT: Check the items that apply:

Do you live in an apartment? O Yes O No How old? ___

Do you live in a house? O Yes O No How old? ___

Other type of housing: mobile home, farm etc. Be specific: ___________________________________

Is there a garage attached? O Yes O No

Is there an abundance of vegetation immediately around your home? O Yes O No

Does your home tend to get dustier than other homes? O Yes O No

Does your home have a basement? O Yes O No

Environment cont.d

Have you ever noticed mold or mildew in your home (basement, bathroom, closet, windowsills etc.?) O Yes O No

POLLEN: Check items which apply:

- O Worse outdoors
- O Worse on windy days
- O Watery eyes
- O Itchy eyes
- O Redness of eyes
- O Worse on clear sunny days
- O Worse outdoors from 7 am to 11 am
- O Air conditioning helps

Does it flare when going from an air conditioned room to open air? O Yes O No
Does the cool air of air conditioning increase your symptoms? O Yes O No
Are nasal and eye symptoms both present? O Yes O No

DUST: Check items which apply:

- O Worse indoors
- O Better outdoors
- O Productive cough
- O Intermittent fever
- O Worse in damp air
- O Dusting or sweeping increases symptoms
- O Sinus trouble
- O Frequent colds
- O Purulent secretions

Flare shortly after going to bed? O Yes O No
Symptoms accentuate on waking? O Yes O No
Symptoms recur or increase each year with the return of cold weather? O Yes O No
Do you experience definite nasal symptoms:
With little or no itching of your eyes? O Yes O No
With itching of your eyes? O Yes O No
Are your symptoms worse when the furnace goes on for the year? O Yes O No
Other? ____

MOLD: Check items which apply:

- O Worse outdoors between 4:30 and 8:30 pm
- O Better in your house
- O Cool evening air increases your symptoms
- O Worse in damp places
- O Flare in the basement
- O Worse on windy days
- O Other: ________________________________
- O Worse after sundown
- O Worse in a certain room
  Which room:_______________________
- O Worse when mowing or playing on grass
- O Worse in a certain home
- O Worse in your house, but not in others

PILLOW: Check items which apply:

O Feather O Synthetic O Down O Foam Rubber O Other:_____________

MATTRESS: Check items which apply:

- O Water bed
- O Cotton
- O Foam rubber
- O Conventional
- O Futon (cotton/foam)
- O Plastic covered
- O Box spring
- O Other:______________________

Environment cont.

Spouse/roommate's mattress:____

BLANKETS: Check items which apply:

- O Wool
- O Cotton
- O Quilt
- O Synthetic

Spouse/roommate's mattress:____

ANIMALS OR PETS: Check items which apply:

- O Dog
- O Cat
- O Bird
- O Fish
- O Rabbits
- O Horse (own/ride)
- O Hamster
- O Guinea pig
- O Cattle
- O Other

Animals in house? O Yes O No
Animals in bedroom? O Yes O No

PLANTS: Check items which apply:

Do you have indoor plants? O Yes O No
If yes, how many and where?
____

FLOORING: Check items which apply:

Carpet/Rugs: O Cotton O Wool O Synthetic
Carpet/Rugs: O Foam O Felt O Straw/Fibre padding
Tile: O Vinyl O Marble O Terrazo
O Ceramic

APPLIANCES: Check items which apply:

Stove: O Gas O Electric Exhaust fan? O Yes O No
Dryer: O Gas O Electric
Refrigerator: O Gas O Electric
Water heater: O Gas O Electric
Location:________________

CLIMATE CONTROL SYSTEMS: Check items which apply:

Heating:

- O Gas forced air
- O Oil forced air
- O Radiator steam/hot water heat
- O Floor furnace
- O Gas or kerosene heating unit
- O Fireplace

Environment cont.

- O Electric baseboard or panel
- O Space heater (vented/unvented)
- O Wall furnace
- O

Other:___________________________________

Air Conditioning:

- O Window
- O Central

Filters:
- O Electrostatic
- O Hepa
- O Fume control
- O Carbon
- O

Other:____________________________________

FURNISHINGS: Check items which apply:

Uphostery:
- O Cotton
- O Synthetic

Cushions:
- O Foam
- O Cotton
- O Synthetic

Window coverings:
- O Metal
- O Wooden
- O Synthetic
- O Cotton

CHEMICALS: Check items which apply:

Do you use strong chemicals (i.e. Disinfectants, bleaches, oven and drain cleaners) in your home?

O Yes O No

If yes, name them: ____

____

Do you use floor and furniture wax and wax remover? O Yes O No

Do you use pesticides in your home? O Yes O No

If yes, name them?____

Do you or have you used a lawn care company? O Yes O No

If yes, name the company: ____

When was the last time? ____

How often do you have the treatments?____

Do you regularly have your home treated for insects? O Yes O No

If yes, name the company and list the specific name of the chemical ______________________

Have you had your home treated for termites? O Yes O No

If yes, when?____

List the product used ____

ELECTROMAGNETIC FORCE

Do you live near a power generating station? O Yes O No

If yes, how near?
- O 150 metres or less
- O 3-5 km
- O 10 km
- O 15 km

Environment cont.

Do you live near an electric distribution substation? O Yes O No
If yes, how near?
O 150 metres or less
O 3-5 km
O 10 km
O 15 km

Do you live near high voltage electrical transmission lines? O Yes O No
If yes, how near?
O 150 metres or less
O 3-5 km
O 10 km
O 15 km

Is there a power transformer near your home? O Yes O No
If yes, how near?
O 150 metres or less
O 3-5 km
O 10 km
O 15 km

Do you live in direct line of a television transmitter? O Yes O No
If yes, how near?
O 150 metres or less
O 3-5 km
O 10 km
O 15 km

Do you live near a microwave tower? O Yes O No
If yes, how near?
O 150 metres or less
O 3-5 km
O 10 km
O 15 km

Do you notice symptoms produced from these?
O TV transmitter O Generating station
O Electric lines O Electric distribution substation
O Transformer O Microwave tower

List symptoms produced in order of severity.

TV transmitter	1.______________	2.______________	3.______________
Electric lines	1.______________	2.______________	3.______________
Transformer	1.______________	2.______________	3.______________
Generating station	1.______________	2.______________	3.______________
Electric substation	1.______________	2.______________	3.______________
Microwave tower	1.______________	2.______________	3.______________

What type of electric lights do you have?
O Incandescent O Fluorescent O Full spectrum

Do you notice any symptoms from your lighting? O Yes O No
If yes, list the symptoms in order of severity.
1.______________ 2.______________ 3.______________

On what type of equipment do you prepare your food?
O Gas O Electric O Microwave

Environment cont.

Do you notice any difference in symptoms from food prepared in a specific way?

Gas	O Yes	O No
Electric	O Yes	O No
Microwave	O Yes	O No

Do you notice any symptoms when near the microwave oven?	O Yes	O No
Do you notice any symptoms from exposure to the TV?	O Yes	O No
Do you have a TV antenna on your home?	O Yes	O No
Do you have cable television?	O Yes	O No
Do you work with computers, electric typewriters?	O Yes	O No

If you experience symptoms, please list in order of severity.

Microwave	1.______________	2.______________	3.______________
Antenna	1.______________	2.______________	3.______________
Cable	1.______________	2.______________	3.______________
Computers	1.______________	2.______________	3.______________
Weather changes	1.______________	2.______________	3.______________
Electric blankets	1.______________	2.______________	3.______________

Do weather changes cause a change in your mental or physical health? O Yes O No

Explain: ____

Do you use electric blankets? O Yes O No

OTHER SUBSTANCES

Do you obtain water from a well?	O Yes	O No	
How deep is the well?	O 25 ft	O 50 ft	O 100 ft
Is it an Artesian well?	O Yes	O No	
Do you have a basement?	O Yes	O No	

What kind of soil does your area have?

O Sandy O Clay O Granite O Shell O Phosphate rock

What kind of material constitutes your basement floors and walls?

O Solid concrete O Concrete O Cinder block O Soil

From what material is the foundation of your home constructed?

O Concrete O Wood O Other:_____________

Do you notice any cracks in the foundation or walls of your basement? O Yes O No

How many stories does your house have? O One O Two O Three

Is your home well insulated? O Yes O No

What type of insulation do you have? ____

Is your home well ventilated? O Yes O No

Explain:____

Environment cont.

Has there been any mining in the immediate vicinity of your home? O Yes O No
If yes, how near?
Are there any land fill areas near your home? O Yes O No
If yes, how near?
Do you know what substances constituted the land fill on which your home was built?
O Yes O No
If yes, what was the substance?____
Do you know the previous use of the land on which your home is built? O Yes O No
If yes, what was the previous use? ____
How long have you lived in this home? ____
Have you noticed any change in your health since being in this home? O Yes O No
If yes, what type of change?
O Heart O Lungs O Gastrointestinal O Head O
Other:________

Do you have an air or water purification system, or both?
O Air O Water O Both O
Type:______________________

Have you had any air sampling done in your home?
Results:____

Do you feel better inside or outside your home? O Inside O Outside

Do you feel better in a particular room or area? O Yes O No
Which one?_____________________

Do you feel worse in a particular room or area? O Yes O No
Which one?_____________________

Inhalant and Chemical Exposure: Check your occupational exposures

- O Office worker
- O Work around cosmetics
- O Professional worker
- O Factory worker
- O Work around fumes
- O Farm worker
- O Work in extreme heat
- O Work in extreme cold
- O Work indoors
- O Salesperson
- O Construction worker
- O Painter
- O Hospital worker
- O Teacher
- O Work with animals
- O Other:______________________

Environment cont.

Check if exposed to: DOUBLE CHECK if you have symptoms from:

- O Dust
- O Fireplace
- O Old home
- O Marshy area
- O Desert area
- O Woody area
- O Prairie
- O Tobacco smoke
- O Linoleum
- O New carpet
- O Old carpet
- O Rugs
- O Wooden floors
- O Diesel fumes
- O Exhaust fumes
- O Gasoline fumes
- O Photocopy paper
- O Varnish
- O Solvents
- O Lacquer
- O Furniture polish
- O Floor wax
- O Incense
- O Mothballs
- O Disinfectants
- O Plastic
- O Dyes
- O Paints
- O Turpentine
- O Alcohol
- O Dry cleaning
- O Pesticides
- O Herbicides
- O Grain dust
- O Mildew
- O Dog inside
- O Cat inside
- O Bird inside
- O Other pets inside
- O Tar
- O Rubber
- O Chemicals
- O Potted plants
- O Cosmetics
- O Nail polish
- O Perfume

List 4 symptoms from these exposures in order of severity:
1._______________ 2._______________ 3._______________ 4. _______________

Thank you for taking the time to fully fill out this questionnaire. We understand this is a significant effort, but the information collected is essential for the accurate determination of health risk, disease causes and appropriate treatment.

Diet Diary

NAME: ____ DATE: ________________

On this sheet of paper please keep a record of the foods and beverages that you eat and drink, approximate amounts, and the time that you consumed them. Include what you eat and drink between meals. Please do not attempt to modify your eating habits just yet – we need to know what your diet consists of now before changes are made. In addition, list any symptoms you experience throughout the day (e.g. drowsiness, headache, bloating, depressed, etc.) and the time of day they occur.

Day 1			Day 2		
Time	Food/Beverage	Symptoms	Time	Food/Beverage	Symptoms

Day 3			Day 4		
Time	Food/Beverage	Symptoms	Time	Food/Beverage	Symptoms

Day 5			Day 6		
Time	Food/Beverage	Symptoms	Time	Food/Beverage	Symptoms

Day 7			Day 8		
Time	Food/Beverage	Symptoms	Time	Food/Beverage	Symptoms