**JOHN F. COOMBS, M.D.**

**John F. Coombs Professional Medicine Corporation**

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**College of Physicians and Surgeons Registration #25147**

**HEALTH QUESTIONNAIRE-CHILD**

This questionnaire is designed to help you examine some of the many factors affecting your child’s health. It is long and detailed, but the time spent in answering all the questions is well worthwhile. Your child’s family history of disease, past illnesses, health habits, your home and school or day care environment all have a direct bearing on health. **PLEASE FILL OUT THIS QUESTIONNAIRE AS CAREFULLY AS YOU CAN.** Many details that seem insignificant to you may have an important bearing on your child’s diagnosis and treatment. Please add any further information that might be of help, either in the margins or on a separate piece of paper. The questionnaire will be kept confidential and is looked at only by the doctor.

**The following information would also be very helpful:**

**· A short written description of your child’s main medical problems, and what help you would like from Dr. Coombs.**

**· A list of treatments that you child has undertaken in the past, both conventional and alternative, and their effect on his/her condition.**

**· A complete list of your child’s medications, both past and present, both drugs and nutritional supplements. Include both the name and dose of each medication.**

**· Copies of previous medical reports and laboratory tests, especially if your child has been** **under the care of a specialist.** [If these are not easily obtained by you beforehand, a request can be sent from this office at the time of your first visit.]

**• PLEASE REMEMBER TO BRING THE COMPLETED QUESTIONNAIRE WITH YOU TO THE APPOINTMENT! DO NOT TRY TO SEND IT HERE IN ADVANCE. It is not worth the risk of having it delayed in the mail.**

**• Your first appointment has been booked for 50 minutes. THIS TIME IS SET ASIDE SPECIFICALLY FOR YOUR CHILD. Since there are others who are waiting for appointments, PLEASE GIVE THIS OFFICE AS MUCH NOTICE AS POSSIBLE IF YOU ARE UNABLE TO ATTEND. Patients who fail to show for an initial appointment will not be given any further appointments with Dr. Coombs.**

**• PLEASE CALL TO CONFIRM YOUR APPOINTMENT A FEW DAYS (MORE THAN ONE BUSINESS DAY) BEFOREHAND.**

**• MANY OF OUR PATIENTS ARE VERY SENSITIVE TO PERFUME AND SCENTED PRODUCTS. PLEASE DO NOT WEAR THESE TO YOUR APPOINTMENT.**

**• DIRECTIONS TO OUR OFFICE IN PERTH ARE POSTED IN THE ‘DIRECTIONS’ SECTION OF THE WEBSITE.**

**NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH yy / mm / dd 1**

**ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE #: HOME (\_\_\_\_)\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_POSTAL CODE\_\_\_\_\_\_\_\_\_ WORK(\_\_\_\_)\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_**

**OHIP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ VERSION CODE:\_\_\_\_\_ Date Questionnaire Completed : yy / mm / dd**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| PAST MEDICAL HISTORY: | | | | | | | | | | FAMILY HISTORY -Has any blood relative had any of the following: circle ‘yes’ or ‘no’ -If so, what relationship: | | | | | | | | | | | |
| **Have you ever had:** |  |  | | Year | **OPERATIONS:** |  |  | Year | |  | | | Anemia | | | yes | | no | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Measles | yes | no | |  | Tonsils | yes | no |  | |  | | | Bleeding tendency | | | yes | | no | | | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| Mumps | yes | no | |  | Appendix | yes | no |  | |  | | | Leukaemia | | | yes | | no | | | **\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Whooping cough | yes | no | |  | Gall bladder | yes | no |  | |  | | | Repeated infections | | | yes | | no | | | **\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Polio | yes | no | |  | Stomach | yes | no |  | |  | | | Crippling infections | | | yes | | no | | | **\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Scarlet fever | yes | no | |  | Breast | yes | no |  | |  | | | Heart disease | | | yes | | no | | | **\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Diphtheria | yes | no | |  | Uterus &\or ovary | yes | no |  | |  | | | Chronic lung disease | | | yes | | no | | | **\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Meningitis | yes | no | |  | Prostate | yes | no |  | |  | | | Tuberculosis | | | yes | | no | | | **\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Infectious mono | yes | no | |  | Hernia | yes | no |  | |  | | | High blood pressure | | | yes | | no | | | **\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Eczema | yes | no | |  | Thyroid | yes | no |  | |  | | | Kidney disease | | | yes | | no | | | **\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Tuberculosis | yes | no | |  | Varicose veins | yes | no |  | |  | | | Asthma | | | yes | | no | | | **\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Exposure to TB | yes | no | |  | Haemorrhoids | yes | no |  | |  | | | Severe allergies | | | yes | | no | | | **\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Malaria | yes | no | |  | Heart | yes | no |  | |  | | | Mental illness | | | yes | | no | | | **\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Hives | yes | no | |  | Other (describe) | yes | no |  | |  | | | Convulsions or fits | | | yes | | no | | | **\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Cancer | yes | no | |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |  | |  | | | Migraine headaches | | | yes | | no | | | **\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Venereal disease | yes | no | |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |  | |  | | | Diabetes | | | yes | | no | | | **\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Arthritis | yes | no | |  | **INJURIES:** |  |  | Year | |  | | | Low blood sugar | | | yes | | no | | | **\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Back trouble | yes | no | |  | Head | yes | no |  | |  | | | Obesity | | | yes | | no | | | **\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Bronchitis | yes | no | |  | Chest | yes | no |  | |  | | | Thyroid trouble | | | yes | | no | | | **\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Pneumonia | yes | no | |  | Abdomen | yes | no |  | |  | | | Peptic ulcer | | | yes | | no | | | **\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Pleurisy | yes | no | |  | Broken bones | yes | no |  | |  | | | Bowel disease | | | yes | | no | | | **\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Asthma | yes | no | |  | Back | yes | no |  | |  | | | Cancer | | | yes | | no | | | **\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Emphysema | yes | no | |  | Other (describe) | yes | no |  | |  | | | Arthritis | | | yes | | no | | | **\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Rheumatic fever | yes | no | |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |  | |  | | | Stroke | | | yes | | no | | | **\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| High blood pressure | yes | no | |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |  | |  | | | Gout | | | yes | | no | | | **\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Heart disease | yes | no | |  | **DRUG REACTIONS:** | | | Year | |  | | | Birth defects | | | yes | | no | | | **\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Anaemia | yes | no | |  | Penicillin | yes | no | |  | |  | | | Other (describe) | | | yes | | no | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Bleeding tendency | yes | no | |  | Sulpha | yes | no |  | |  | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | |
| Blood transfusion | yes | no | |  | Foods | yes | no | |  | |  | | |
| Hepatitis (yellow jaundice) | yes | no | |  | Cosmetics | yes | no |  | |  | | | **Family member:** | | **Age if**  **living:** | | | | | **Health problems?**  **Age of death if deceased.** | |
| Ulcer | yes | no | |  | Other drugs | yes | no |  | |  | | |
| Haemorrhoids | yes | no | |  | (Describe)\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |  | |  | | | Grandparents: | |  | | | | |  | |
| Bladder infections | yes | no | |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |  | |  | | | 1. | |  | | | | |  | |
| Kidney disease | yes | no | |  | **HOSPITALISATIONS:** | | |  | |  | | | 2. | |  | | | | |  | |
| Hay fever / sinusitis | yes | no | |  | Reason: | | | Year | |  | | | 3. | |  | | | | |  | |
| Glaucoma | yes | no | |  |  | | |  | |  | | | 4. | |  | | | | |  | |
| Nose bleeds | yes | no | |  |  | | |  | |  | | | Father | |  | | | | |  | |
| Bowel disease | yes | no | |  |  | | |  | |  | | | Mother | |  | | | | |  | |
| Emotional illness | yes | no | |  |  | | |  | |  | | | Brothers/Sisters | |  | | | | |  | |
| Other (describe) | yes | no | |  |  | | |  | |  | | | 1. | |  | | | | |  | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  | |  |  | | |  | |  | | | 2. | |  | | | | |  | |
| **X-RAYS & OTHER TESTS:** Describe results: | | | Describe results: | | | | | | | | | | 3. | |  | | | | |  | |
| Chest x-ray | yes | no | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 4. | |  | | | | |  | |
| Stomach x-ray | yes | no | |  | | | | | | | |  | 5. | |  | | | | |  | |
| Bowel x-ray | yes | no | |  | | | | | | | |  | 6. | |  | | | | |  | |
| Gallbladder x-ray | yes | no | |  | | | | | | | |  |  | |  | | | | |  | |
| Kidney x-ray | yes | no | |  | | | | | | | |  |  | |  | | | | |  | |
| Electrocardiogram | yes | no | |  | | | | | | | |  |  | |  | | | | |  | |
| Other Tests that were abnormal: | | | |  | | | | | | | |  |  | |  | | | | |  | |
|  | | | |  | | | | | | | |  |  | |  | | | | |  | |
|  | | | |  | | | | | | | |  |  | |  | | | | |  | |
| **PLEASE LIST ALL YOUR MEDICATIONS BELOW OR ON OTHER SIDE OF PAGE.** | | | | | | | | | | | |  |  | |  | | | | |  | |

**DESCRIPTION OF CURRENT SYMPTOMS & HEALTH PROBLEMS**

#### HAVE YOU EVER HAD ANY OF THE PROBLEMS DESCRIBED BELOW? Circle ‘Yes’ Or ‘No’, And GIVE DETAILS if ‘Yes’

**2**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **GENERAL**  Tired easily, feeling of weakness  Marked weight change  Night sweats  Persistent fever  Sensitivity to heat  Sensitivity to cold  **SKIN**  Rashes  Change in colour  Change in hair  Change in nails  **EYES**  Trouble seeing  Eye pain  Inflamed eyes  Double vision  Worn glasses  **EARS**  Loss of hearing  Ringing in ears  Discharge  **NOSE**  Loss of smell  Frequent colds  Obstruction  Sinus congestion  Excess discharge  Nose bleeds  **MOUTH/ DENTAL**  Canker sores  Sore or bleeding gums  Sore tongue  Any silver/mercury fillings? How many?  Any root canals?  Other dental problems  **THROAT**  Post nasal drainage  Soreness  Hoarseness  **BREAST**  Lumps  Discharge  **HEART&LUNGS**  Cough, persistent  Sputum (phlegm)  Bloody sputum  Wheezing  Chest pain or discomfort  Pain on breathing  Difficulty breathing  Swelling of ankles  Bluish fingers or lips  High blood pressure  Palpitations, irregular heart beat  Vein trouble | yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes | no  no  no  no  no  no  no  no  no  no  no  no  no  no  no  no  no  no  no  no  no  no  no  no  no  no  no  no  no  no  no  no  no  no  no  no  no  no  no  no  no  no  no  no  no  no  no | GIVE DETAILS BELOW | **DIGESTIVE SYSTEM**  Change in appetite  Difficulty swallowing  Heartburn  Abdominal discomfort  Belching, burping  Flatulence (excess farting)  Abdominal bloating  Nausea  Vomiting  Rectal bleeding  Tarry (black)stools  Dark urine  Jaundice (yellow skin)  Constipation  Need for laxatives  Diarrhoea  Haemorrhoids | yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes | no  no  no  no  no  no  no  no  no  no  no  no  no  no  no  no  no | GIVE DETAILS BELOW |
| **BOWEL HABITS**  Average frequency of bowel movements:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Longest time between bowel movements (e.g., if travelling or not well):  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Have you ever travelled in the tropics, or had traveller's diarrhoea?  If so, describe: | | | |
| **GENITOURINARY**  Frequent urination (day)  Frequent urination (night) Feel need to urinate without much urine  Unable to hold urine  Pain or burning of urination  Blood in urine  **JOINTS/BONES/MUSCLE**  Muscle cramps  Muscle weakness  Pain in joints  Swollen joints  Stiffness  Deformity of joints  **NERVOUS SYSTEM**  Headaches  Dizziness  Fainting  Convulsions or fits  Nervousness, anxiety  Sleeplessness, insomnia  Depression  Memory loss  Change in sensation  Poor co-ordination  Weakness or paralysis  **HORMONAL**  Thyroid trouble  Adrenal trouble  Cortisone treatment  Diabetes | yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes  yes | no  no  no  no  no  no  no  no  no  no  no  no  no  no  no  no  no  no  no  no  no  no  no  no  no  no  no |  |
| **GYNAECOLOGY**  Started menstruating at age\_\_\_\_\_\_ or N/A\_\_\_\_\_\_  Interval between periods:\_\_\_\_\_\_days duration:\_\_\_\_\_\_\_\_\_days  Flow: light normal heavy Date of last period\_\_\_\_\_\_\_\_\_\_\_  Pain with periods? yes no mild severe  Problems with vaginal discharge: \_\_\_yes \_\_\_no \_\_\_in past, not now  Premenstrual symptoms: \_\_\_ yes \_\_\_ no.  Describe: Mood changes Weight gain Retain fluid Cravings Abdominal symptoms Tender breasts Fatigue Other: \_\_\_\_\_\_\_\_\_\_ | | | |
| **USE OF HEALTH PROFESSIONALS**  Date of last complete medical exam\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  During the past year, how many visits have you made to each of the following :  \_\_\_\_ Family doctor \_\_\_\_\_\_Psychiatrist  \_\_\_\_ Specialist doctor \_\_\_\_\_\_ Other counsellor  \_\_\_\_ Hospital emergency \_\_\_\_\_\_ Dentist | | | |

**Have you ever used, or would you ever consider using, any of the following "alternative" methods of healing?** (Mark the applicable ones)

\_\_Chiropractor \_\_Massage therapist \_\_Naturopath \_\_Homeopath \_\_Acupuncture\_\_ other (please describe)

**NUTRITION AND HEALTH**

**DIETARY HISTORY**

**3**

**Have your eating habits changed over the past 5 years?** (Yes No) If so, describe the changes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you currently following a special diet?** (Yes No) If so, describe what kind of diet:

**How many meals per week do you skip?** \_\_\_\_\_\_\_meals per week. **Which ones?**  \_\_\_breakfast \_\_\_lunch \_\_\_supper

**On the average, how many times per week to you eat the following kinds of foods?**

\_\_\_\_ “Convenience” foods such as TV dinners, Kraft dinner, instant breakfast, canned dinners (stews, spaghetti, etc.), food mixes

\_\_\_\_ At fast food outlets (McDonald’s, Tim Horton’s, Col. Saunders, etc.) \_\_\_\_\_\_\_\_ Other restaurants

**Who prepares most of your meals?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How often do you read labels while shopping in order to avoid unhealthy ingredients?** \_\_\_\_\_ Rarely \_\_\_\_ Sometimes \_\_\_\_\_Often

**Indicate your average food selections for each meal:**

Breakfast\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lunch\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supper\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Snacks\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**USE OF FOOD GROUPS:**

**PROTEIN FOODS: Circle the ones you use daily; underline the ones you use at least a few times each week:**

Red meats/ chicken/turkey & other fowl/Fish/Eggs/ Milk products/ beans & soy products/ seeds & nuts

**STARCHES: Circle the ones you use daily; underline the ones you use at least a few times each week:**

Whole grain (brown) breads/ White or light brown breads/ potatoes/ white rice/ brown rice/ white pasta/whole grain pasta/ dry breakfast cereals/cooked breakfast cereals/ corn & corn products

**VEGETABLES & FRUIT: Circle the ones you use daily:**

Raw vegetables/salads/ starchy vegetables (squash, corn, root vegetables) Fresh fruit/ cooked, canned or dried fruit

**SWEETS:** **Underline the ones you use at least a few times each week:**

White or brown sugar/ corn syrup/ molasses/ maple syrup/ honey/ candy

**FATS: Underline the ones that you use at least a few times a week:**

Fried foods/ butter/ margarine/ cream/ gravies/ lard/ vegetable oil

What kind of vegetable oil do you usually use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BEVERAGES: Circle the ones you use daily; underline the ones you use at least a few times each week:**

Water/ black tea/ green tea/ herbal teas/coffee/ decaffeinated coffee/ colas/ other soft drinks/ diet soft drinks

**Have you ever taken vitamins or food supplements?** \_\_\_Yes \_\_\_\_No. If so, do you feel any better for taking them? \_\_\_Yes \_\_\_\_No

**PLEASE LIST ON A SEPARATE PIECE OF PAPER A COMPLETE LIST OF ALL NUTRITIONAL SUPPLEMENTS YOU ARE TAKING REGULARLY, AND INCLUDE THIS WITH THE QUESTIONNAIRE. IF SOME OF THEM ARE A DEFINITE HELP TO YOU, INDICATE WHICH ONES.**

**Hidden food sensitivities are a very common factor in chronic illness.** Some of the more common ones are listed below. Are there any of these foods that have given you have bad reaction, mild or severe, either now or in the past (such as indigestion, headache, rashes, swelling, changes in your mood, wheezing, etc.)? If so, indicate which foods below, and describe briefly the reaction you get:

\_\_\_\_ artificial flavourings, colourings, or other food additives

\_\_\_\_ milk, or milk products

\_\_\_\_old cheeses, or vinegar, or pickled products

\_\_\_\_ beer, wine, or alcohol

\_\_\_\_ coffee or tea

\_\_\_\_ sugar or highly sweetened foods

\_\_\_\_ chocolate or cocoa

\_\_\_\_ wheat or any other grains (specify)

\_\_\_\_ bread (especially when fresh), or other baked goods

\_\_\_\_ eggs

\_\_\_\_ fish

\_\_\_\_ shellfish

\_\_\_\_ corn

\_\_\_\_ nuts, especially peanuts or peanut products

\_\_\_\_ tomatoes, or tomato products

\_\_\_\_ oranges or grapefruit

\_\_\_\_ any other foods:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Food cravings can be a sign of hidden food sensitivity**. Look at the list of foods above, and decide whether there are any of them which you crave, or that you would find very difficult to give up eating. If so, list these below:

**ENVIRONMENTAL AND TOXIC INFLUENCES ON HEALTH**

Environmental effects on health can be very significant. Please indicate whether you have noticed an influence from any of the following environmental factors. If so, please indicate by underlining the appropriate items, and **describe your reaction** beside them. Some of these factors may be significant even if you are not aware of any obvious reaction to them. If you have had in the past **significant exposures** to mould, chemicals, or electromagnetic fields, (either at home or work) please also **circle** these below.

**4**

|  |  |
| --- | --- |
| ENVIRONMENTAL FACTOR:  (underline the ones you react to)  **DUST**  House dust  Other kind of dusts (road, wood, etc.)  **MOULDS**  Damp basements  Old buildings/water damaged buildings  Old barns, Old hay/straw  Air conditioners  Other:  **ANIMALS**  Dog/cat/horse/ other (describe)  **FEATHERS**  Feather pillows  Birds  **POLLENS**  Trees  Grasses  Rag weed  Country air  Other pollens:  **SMOKE**  Wood smoke  Tobacco smoke  Other smoke:  **CHEMICALS**  Engine exhaust, traffic  Cleaning solutions  Paint fumes/ refinishing fumes  Pesticide/herbicide sprays  Perfumes/scented products  Newsprint  City air  Indoor air in general  Toxic metals  Swimming pools  Other chemicals:  **WEATHER**  Hot, muggy weather  Damp or muggy weather  Spring or fall weather  Cold weather  Approaching storms  Change in location  Other climactic effects:  **ELECTROMAGNETIC FIELDS**  Fluorescent lighting  Computer monitors  High-voltage transmission lines  X-ray or nuclear radiation  Other electromagnetic fields:  **DRUGS**  Aspirin, or other pain relievers  Antibiotics  Others (please describe) | DESCRIBE YOUR REACTION OR SIGNIFICANT EXPOSURE NEXT TO THE FACTORS SELECTED. |

**MORE ON ENVIRONMENT AND HEALTH**

**1.** **Have you ever had allergy tests?** \_\_\_\_\_yes \_\_\_\_\_no If so, what did they show? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5**

**2. Have you ever had allergy injections?** \_\_\_\_\_yes \_\_\_\_\_no If so, to what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If so, did the allergy injections help you (yes/no), or make your symptoms worse (yes/no)?

**3. Approximately when was your home built?** \_\_\_\_\_\_\_\_\_\_\_

**4. What kind(s) of heating system does your home have?**\_\_\_ oil \_\_\_natural gas

\_\_electric (forced air) \_\_ electric (baseboard) \_\_\_wood \_\_\_other:\_\_\_\_\_\_\_\_

**5. What kinds of flooring does your home have in the bedrooms?** \_\_\_Carpet \_\_Wood \_\_\_Linoleum \_\_Other

**6. Does your home have a damp or musty basement, or visible mould around windows or elsewhere?**

\_\_\_ Yes \_\_\_No If yes, please elaborate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**7. In your home, is there a:** smoke detector? carbon monoxide detector? fire extinguisher? first-aid kit?

**8. When in a car, how often do you use a safety belt?**

\_\_\_Rarely \_\_\_Sometimes \_\_\_Always, or almost always

**USE OF DRUGS AND CHEMICALS**

Heaviest use of alcohol in the past? \_\_\_\_\_drinks per day/week/month

Current use of alcohol? \_\_yes \_\_no. \_\_\_\_\_drinks per day/week/month

Heaviest use of cigarettes in the past? \_\_yes \_\_no. \_\_\_\_\_packs per day/week/month

Current use of cigarettes? \_\_yes \_\_no. \_\_\_\_\_packs per day/week/month

Other forms of tobacco consistently used (now or in the past): \_\_\_\_pipe \_\_\_\_cigar

Past use of marihuana? \_\_yes \_\_no . \_\_\_\_times per day/week/month

Current use of marihuana? \_\_yes \_\_no . \_\_\_\_times per day/week/month

Past use of 'recreational' or 'street' drugs? \_\_yes \_\_no . \_\_\_\_times per day/week/month

Current use of 'recreational' or 'street' drugs? \_\_yes \_\_no . \_\_\_\_times per day/week/month

Use of over-the-counter medications on a regular basis? \_\_yes \_\_no Circle which ones below:

Aspirin-Tylenol-Other pain relievers-Cough/cold remedies-Antihistamines-Laxatives-Other: \_\_\_\_\_\_\_\_\_\_

**PHYSICAL ACTIVITY AND HEALTH**

**1. ON THE AVERAGE, HOW MUCH PHYSICAL EXERCISE YOU GET EACH DAY?**

\_\_\_ **None, or very little** (less than 1/2 mile walking, or less than ten flights of stairs)

\_\_\_ **Some** (1/2 -1 1/2 miles walking or 10-30 flights of stairs or daily activities involving some physical activity such as: raising young children, scrubbing floors, gardening, or work which involves being on your feet most of the time)

\_\_\_ **Fairly active** (over 30 flights of stairs or 1 1/2 -3 miles of walking or daily activities involving fairly active physical effort such as construction work, farming, moving heavy objects by hand, etc.)

\_\_\_ **Very active** (over three miles of walking or daily hard physical labour, etc.)

**2. DESCRIBE ANY REGULAR, VIGOROUS PHYSICAL ACTIVITY YOU DO.** (Vigorous enough to make your heart pound, your breathing deep, and bring on sweating: such as: sports, running, heavy manual labour)

**ACTIVITY**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DONE FOR**: \_\_\_\_\_\_ minutes/hours, \_\_\_\_\_\_\_\_times per week

**3. WHAT, IF ANY, FACTORS MAKE IT DIFFICULT FOR YOU TO KEEP PHYSICALLY ACTIVE?**

\_\_\_ Current illness or general condition

\_\_\_ Lack of time to exercise

\_\_\_ Lack of facilities

\_\_\_ Other (describe): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**4. ARE YOU OUT OF BREATH AFTER WALKING UP A FLIGHT OF STAIRS?** \_\_\_ Yes \_\_\_No

**5. HOW FAR CAN YOU WALK WITHOUT HAVING TO STOP TO REST?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**6. HOW FAR CAN YOU RUN WITHOUT HAVING TO STOP TO REST? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**LOW BLOOD SUGAR QUESTIONNAIRE**

Low blood sugar (hypoglycaemia) is a common problem affecting mood and energy, yet it frequently goes unrecognised.

**6**

|  |  |  |  |
| --- | --- | --- | --- |
| **FOR EACH QUESTION PUT AN 'X' IN THE APPROPRIATE COLUMN ON THE RIGHT→** | RARELY | SOME  TIMES | OFTEN |
| 1. Do you crave sweets? |  |  |  |
| 2. Do you eat sweets every day? |  |  |  |
| 3. Did you eat a lot of sweets as a child? |  |  |  |
| 4. Do you have coffee or tea or cola every day? |  |  |  |
| 5. You find it difficult to go without sweets? |  |  |  |
| 6. Do you find it difficult to go without coffee or tea? |  |  |  |
| 7. Do you feel better if you eat between meals? |  |  |  |
| 8. If your meals are late, do you feel weak, shaky, sick, irritable or tired? |  |  |  |
| 9. Do get a headache if you do not eat? |  |  |  |
| 10. Do you get ravenously hungry if you do not eat? |  |  |  |
| 11. Do you get sweaty if you go too long without eating? |  |  |  |
| 12. If you get light headed or trembling, does food or sweets make you feel better? |  |  |  |
| 13. If you feel tired does food or sweets make you feel more energetic? |  |  |  |
| 14. Do you use sweets or coffee or tea to make you feel less tired? |  |  |  |
| 15. If you get irritable, does eating make your mood improve? |  |  |  |
| 16. Do you feel tired or sleepy after meals? |  |  |  |
| 17. Do you feel tired or sleepy after a large starchy meal or a lot of sweets? |  |  |  |
| 18. Do you ever wake-up at night hungry? |  |  |  |
| 19. Do you ever fall asleep while sitting still? |  |  |  |
| 20. Does your heart ever pound, or go fast, or skip beats? |  |  |  |
| 21. Do you feel frightened or tearful for little or no reason? |  |  |  |
| 22. Do you feel cranky, irritable, sad or miserable for little or no reason? |  |  |  |
| 23. Do you get upset or worried about little things? |  |  |  |
| **TOTAL THE NUMBER OF RESPONSES IN EACH GROUP FOR THE 23 QUESTIONS ABOVE →** |  |  |  |

**SOME ADDITIONAL QUESTIONS: YES NO**

|  |  |  |
| --- | --- | --- |
| 1. Is there diabetes or low blood sugar in your family? |  |  |
| 2. Is there a history of alcoholism in your family? |  |  |
| 3. Have you ever been a heavy drinker? |  |  |
| 4. Do you have allergies? (Eczema, hay fever, asthma, etc.) |  |  |

5. How many cups per day do you have of the following: coffee \_\_\_\_, black tea\_\_\_\_, cola\_\_\_\_?

6. Who are your closest blood relatives who have (or have had) problems with alcohol, or have been prone to excessive drinking?

\_\_ Mother \_\_\_ Father \_\_Sister or brother \_\_Others(Describe)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. Have you ever had a blood sugar test? \_\_\_ Yes \_\_\_ No

If so, what were the results? \_\_\_\_\_ Normal \_\_\_\_\_ Abnormal \_\_\_\_\_ Don't know

**CANDIDA QUESTIONNAIRE for CHILDREN**

Yeast overgrowth in the intestinal tract is a common problem affecting mood, energy, and resistance to infection, yet it often goes unrecognised. Following is a list of points that suggest a role for this in your child's health:

**7**

|  |  |  |  |
| --- | --- | --- | --- |
| **FOR EACH QUESTION, CIRCLE THE NUMBER IN THE COLUMN THAT CORRESPONDS TO THE CHILD'S DEGREE OF SYMPTOMS:**  **MILD, MODERATE, OR SEVERE** | **POINT SCORE** | | |
| **MILD** | **MODE RATE** | **SEVERE or PERSISTENT** | |
| 1. During the 2 years before your child was born, was the mother bothered by recurrent vaginitis, menstrual irregularities, premenstrual tension, fatigue, headaches, depression, digestive disorders, or "feeling bad all over"? | 25 | 30 | 35 | |
| 2. Was your child bothered by thrush? | 10 | 15 | 20 | |
| 3. Was your child bothered by frequent diaper rashes in infancy? | 10 | 15 | 20 | |
| 4. During infancy, was your child bothered by colic and irritability lasting over 3 months? | 10 | 15 | 20 | |
| 5. Are his or her symptoms worse on damp days or in damp or moldy places? | 10 | 20 | 30 | |
| 6. Has your child been bothered by recurrent or persistent "athlete's foot" or chronic fungus infections of skin or nails? | 20 | 30 | 40 | |
| 7. Has your child been bothered by recurrent hives, eczema or other skin problems? | 5 | 10 | 15 | |
| 8. Has your child received 4 or more courses of antibiotic drugs during the past year? Or has the child received continuous "preventive" courses of antibiotics? |  | 60 |  | |
| 9. Has your child received 8 or more courses of antibiotics during the past three years? |  | 30 |  | |
| 10. Has your child experienced recurrent ear problems? | 5 | 10 | 15 | |
| 11. Has your child had tubes inserted in his ears? |  | 10 |  | |
| 12. Has your child been labeled "hyperactive"? | 10 | 15 | 20 | |
| 13. Is your child bothered by learning problems? | 5 | 10 | 15 | |
| 14. Does your child have a short attention span? | 5 | 10 | 15 | |
| 15. Is your child persistently durable, unhappy, and hard to please? | 5 | 10 | 15 | |
| 16. As your child been bothered by persistent or recurrent digestive problems, including constipation, diarrhea, bloating, or excessive gas? | 10 | 20 | 30 | |
| 17. As he been bothered by persistent nasal congestion, cough, and/or wheezing? | 5 | 10 | 15 | |
| 18. Is your child unusually tired or unhappy or depressed? | 5 | 10 | 20 | |
| 19. Has your child been bothered by recurrent headaches, abdominal pain, or muscle aches? | 10 | 15 | 20 | |
| 20. Does your child crave sweets? | 5 | 10 | 15 | |
| 21. Do you feel that your child isn't well, yet diagnostic tests have not yet revealed the cause? | 5 | 10 | 15 | |
| **TOTAL SCORE →** |  |  |  | |

SCORE RESULTS: 60 or more → Possible health effect from yeast overgrowth in the intestine

100 or more → Probable health effect from yeast overgrowth in the intestine

140 or more → Almost certain health effect from yeast overgrowth in the intestine