Gastro-Intestinal Tract

Daily bowels Movements:

- ○ 0-1
- ○ 2
- ○ 3
- ○ 4+

Diagnosis of any of the Following :

- ○ Crohn's
- ○ Gastritis
- ○ Enteritis
- ○ Diverticulitis

Diagnosed Gastroparesis (Paralysis of the Stomach) :

- ○ Yes
- ○ No

Hiatus Hernia :

- ○ Yes
- ○ No

Tongue Coated, esp. upon rising (white, yellow, green, brown) :

- ○ Yes
- ○ No

Diarrhea/Constipation
(circle all that apply above) :

- ○ Yes
- ○ No

Stomach/Intestinal Ulcers
(circle all that apply above):

- ○ Yes
- ○ No

Diagnosed with Gastro-Intestinal "Cancer"
(Location) :

- ○ Yes
- ○ No

Recurring Gas Problems :

- ○ Yes
- ○ No

Please list any G.I. tract concerns not listed :

_____
_____
_____
_____

Liver/Gallbladder/Blood

Stomach Discomfort with Fats or Dairy /Bloating or Pain (explain) :

_____
_____
_____

- Yes
- No

White or Light Stool :

- Yes
- No

Mid-Back Pain (notably after eating):

- Yes
- No

Discoloration as "Liver Spots"/ Brown Spots (Not Freckles) :

- Yes
- No

Irregularities in Skin Pigmentation/Changes :

- Yes
- No

Jaundice of Eyes/Skin
(circle all that apply above) :

- Yes
- No

Anemia :

- Yes
- No

Diagnosed with Hepatitis :

- A
- B
- C

Alcohol Consumption :

- Don't Drink
- Daily
- Weekly
- Monthly or Less

Cardiovascular System

Chest Discomfort/Pain/Angina (Circle all that apply):

- Yes
- No

History of Myocardial Infarction (Heart Attack) :

Yes No

Any Cardiovascular Surgery :

Pacemaker Stents Open HeartSurgery

Experiencing Pressure on the Chest :

Yes No

Experiencing "Prickly Pains?
(list location)_____

Yes No

Integumentary System (Skin)

Do you currently have/diagnosed:

Eczema

Dermatitis

Psoriasis

Other skin

Excessively oily skin :

Yes No

Tattoos :

Yes No Removed

Lymphatic System

Hair Loss (explain)_____
_____

Have you ever been diagnosed with swollen lymph nodes/lymphedema (explain)_____
_____
_____

Yes No

Have You Every had Lymph Nodes Surgically Removed/which area/ how many (explain) :
_____
_____

Yes No

Have you ever had Edema (Fluid Retention) List location:
_____
_____

Diagnosed with any of the following:

Fibromyalgia Scleroderma

Cold & Flu-like Symptoms
Sore Throat/ Sinus Problems (Circle all that apply above):

Yes No

Poor Memory/Brain Fog:

Yes No

Blurred Vision:

Yes No

Mucous around eyes upon waking:

Yes No

Have you Been Diagnosed With "Cancer" Location/Year:_____
_____
_____

Any Type of Non-Malignant Mass/Tumor/ If so Please list location :
_____
_____

AIDS / HIV+ : (circle all that apply)

Yes No

Decreases Platelet Count:

Yes No

Ever experienced Appendicitis/Appendectomy :

Yes No

Tonsillectomy (Tonsils Removed) :

Yes No

Ever Have any of the Following (Circle all that apply)
Boil/Pimple/Cyst/Abscess

Yes No

Gout

Yes No

Sleep Apnea

Yes No

Urinary System (Kidneys & Bladder)

Burning in Urination :

Yes No

Concerns with Weak Bladder or Urinary Incontinence :

Yes No

Concerns with Restricted Urine Flow :

Yes No

Concerns with Kidney Stones:

Yes No

Concerns with Nephritis :

Yes No

Concerns/Cramping/Pain Mid-to Lower Back either Unilateral or Bilateral:

Yes No

Concerns /Lower Back Weakness of Strength :

Yes No

Concerns with Sciatica:

Yes No

Respiratory System

Have you ever Had Any of the Following : (Circle all that apply/explain)
Bronchitis/Asthma/COPD/Emphysema/Pneumonia
_____
_____

Any Difficulty/Pain Taking Deep Breaths:
Yes No

Any Difficulty with A Collapsed Lung :

Yes No

Frequent Cough:
Yes No

Expectorated Mucus Color (with cough/circle all that apply) clear/yellow/green/ brown/black
Yes No

Do You Use a Nebulizer/Inhaler :
Yes No

Do you know your Oxygen Saturation (SPO2) List:
Yes No

Have You Ever Received A Diagnosis of "Lung Cancer" :
Yes No

How much do You Smoke i.e., Packs/Day or Cigarettes/Day (explain)
_____
_____
_____

Environmental/Toxic Exposure

Have you ever Been Exposed to Nuclear Wastes/by- products nuclear waste/heavy metals/toxic chemicals (circle all that apply/explain)
_____
_____
_____

Have you ever Been Exposed to Toxic Substances Asbestos or Coal Mines:

○ Yes ○ No

Have you Gone Through Chemotherapy or Radiation, if so, list how many treatments.

_____

_____

○ Yes ○ No

Have you Received the "Standard Vaccinations" or “Out of Country/Travelling Vaccinations”:

○ Yes ○ No

Have you ever Received a Flu Shot :

○ Yes ○ No

Recreational Drug Usage (Highly Confidential Information only for Health Protocol) If so, Please list :

_____

_____

_____

Date:_____ Signature _____

Date : _____ Legal Guardian _____

This is acknowledging and signing the MeSozo Health & Wellness Health Form and all it entails.
(If a minor, the signature of legal guardian must be given with suitable notation of the fact that it is the guardian or responsible person who is signing).