

JOHN F. COOMBS, B.Sc., M.D.
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HEALTH QUESTIONNAIRE

This questionnaire is designed to help you examine some of the many factors affecting your health. It is long and detailed, but the time spent in answering all the questions is well worthwhile. Your family history of disease, your past illnesses, your health habits, your home and work environment all have a direct bearing on your 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 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 main medical problems**, and what help you would like from Dr. Coombs.
- A **list of treatments that you have undertaken in the past**, both conventional and alternative, and their effect on your condition.
- A **complete list of your medications**, both past and present, both drugs and nutritional supplements.
- Copies of **previous medical reports** and laboratory tests, especially if you have 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 YOUR 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 FOR YOU ALONE.** Since there are others who are waiting for appointments, **PLEASE GIVE THIS OFFICE AS MUCH NOTICE AS POSSIBLE IF YOU ARE UNABLE TO ATTEND.**

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

• **PLEASE DO NOT WEAR PERFUME, AFTER SHAVE, OR OTHER SCENTED PERSONAL PRODUCTS TO THE APPOINTMENT. SOME PATIENTS WHO COME TO THIS OFFICE HAVE VERY SERIOUS REACTIONS ON EXPOSURE TO THESE.**

YOUR APPOINTMENT HAS BEEN BOOKED FOR:

_____ at _____ O'clock

(Please find directions below)

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DIRECTIONS TO FALLBOOK, ONTARIO

FROM OTTAWA:

The slow but sure way, via Perth: (This route is preferable when roads are bad in winter.)

Travel Highway #417 west, past the exits for Kanata and Stittsville, taking exit #145 for Highway #7 west. Travel Highway #7 west, past Carleton Place to Perth. Continue along Highway #7 through Perth, and at the third set of traffic lights, turn right onto provincial highway #511 north (which begins at highway #7). Travel 7 km. north to Balderson, turn left onto County Road #7, and follow the directions 'FROM BALDERSON' below.

The shorter way, via Ferguson Falls:

Those travelling from Carleton Place and Ottawa who are confident with back roads can take a shortcut from Highway #7 which will save about 10 minutes: 12 km. west of the traffic lights on highway #7 at Carleton Place, beside a grey stone church very close to the road, there is a right turn clearly indicated for Fergusons Falls and Lanark. This is County Road #15 (paved), which winds scenically 6 km to Fergusons Falls (follow the main road all the way). Another 2.8 km. after Ferguson Falls is a fork in the road, with the main highway turning right towards Lanark, and a smaller paved road heading straight ahead towards Balderson. Take the smaller road going straight ahead, and wind your way the 9.5 km. to the village of Balderson. At Balderson, there is a stop sign at the point the road meets Highway #511. Continue straight ahead, across Highway #511, and follow the paved road (County road #7). Continue with the directions 'FROM BALDERSON' below.

FROM BALDERSON

As you continue west from Balderson along County Road #7, take the first paved road to the right, which is 2.7 km. from Balderson (directions to Fallbrook are indicated here). Follow the road another 3 km. into the village of Fallbrook. Immediately as you enter the village, you will cross a tiny river marked the Fall River, and after the bridge you will see two red brick houses on the left side of the road, one behind the other. Beside these brick houses is a small laneway marked 'Walter's Lane' (the street sign is on the right hand side of the road).

-Turn left down this gravel laneway about 500 ft., past the second red brick house and small barn, and over a small causeway which traverses a swamp. Patient parking is on the left as soon as you enter the cleared area in front of the house.

FROM ALMONTE AND POINTS NORTH:

-Take County Road 16 west from Almonte, which begins at the Petro-Canada gas station on Highway #15. Travel through the village of Middleville to Hopetown

-County Road 16 meets provincial highway #511 at Hopetown at a T-junction: turn left (south) onto highway #511 toward Lanark. Travel south on Highway #511 to Lanark.

FROM LANARK VILLAGE:

-Travel through Lanark village to the T-junction at the south end of the village.

-Instead of turning left to follow highway #511, turn right (west), and travel across a bridge and up a hill out of town.

-After travelling about 6.5 km., you will come to a bridge crossing the Mississippi River and immediately following, an ascending hill, with a clearly lit T junction with a paved road on the left.

-Turn left (south) at this T junction; this is the road to Fallbrook

-About one mile along this road you will come into the village of Fallbrook. Travel into the village, down a hill, and at the foot of the hill you will see on the left side a sign indicating Walter's Lane. Turn right and travel to the end of this laneway. **Winter route:** If roads are bad in winter, you may prefer to follow highway #511 south from Lanark to the village of Balderson, turn right along county road #7. Then follow the directions 'FROM BALDERSON' above.

FROM KINGSTON:

-Travel on Highway #15 north, through Elgin and Portland, to Lombardy. Turn left onto County Road #1, and travel through Rideau Ferry to Perth. County Road #1 turns into Gore Street in Perth. Continue on Gore Street, following the highway indicator signs for Highway #7. You will make a jog to the left on Foster St., then right onto Wilson St. Continue north to the end of Wilson Street, at Highway #7. Turn left at the lights at Highway #7, then turn right at the next intersection, which is Highway #511 north. Turn left (west) at Balderson, then follow the directions 'FROM BALDERSON' above.

FROM THE WEST: Take Highway #7 east to the first set of traffic lights at Perth. Turn left onto Highway #511 north, and continue as in the first paragraph above, 'via Perth'.

· **PLEASE PARK IN THE PARKING LOT AT THE FOOT OF THE STAIRWAY. WALK UP THE STAIRS TO THE FRONT DOOR OF THE HOUSE. IF YOU CANNOT CLIMB STAIRS (10 SHORT STEPS), YOU MAY USE THE UPPER PARKING LOT AND WALK ACROSS THE LAWN TO THE FRONT DOOR. IF YOU WILL NEED FULL HANDICAPPED ACCESS, PLEASE NOTIFY US IN ADVANCE SO THAT WE CAN BE PREPARED TO GIVE YOU ASSISTANCE.**

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

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:

Measles	yes no	Tonsils	yes no
Mumps	yes no	Appendix	yes no
Whooping cough	yes no	Gall bladder	yes no
Polio	yes no	Stomach	yes no
Scarlet fever	yes no	Breast	yes no
Diphtheria	yes no	Uterus &/or ovary	yes no
Meningitis	yes no	Prostate	yes no
Infectious mono	yes no	Hernia	yes no
Eczema	yes no	Thyroid	yes no
Tuberculosis	yes no	Varicose veins	yes no
Exposure to TB	yes no	Haemorrhoids	yes no
Malaria	yes no	Heart	yes no
Hives	yes no	Other (describe)	yes no
Cancer	yes no	_____	
Venereal disease	yes no	_____	

INJURIES:

Arthritis	yes no	Head	yes no
Back trouble	yes no	Chest	yes no
Bronchitis	yes no	Abdomen	yes no
Pneumonia	yes no	Broken bones	yes no
Pleurisy	yes no	Back	yes no
Asthma	yes no	Other (describe)	yes no
Emphysema	yes no	_____	
Rheumatic fever	yes no	_____	

DRUG REACTIONS:

High blood pressure	yes no	Penicillin	yes no
Heart disease	yes no	Sulpha	yes no
Anaemia	yes no	Foods	yes no
Bleeding tendency	yes no	Cosmetics	yes no
Blood transfusion	yes no	Other drugs	yes no
Hepatitis (yellow jaundice)	yes no	(Describe)_____	
Ulcer	yes no	_____	

HOSPITALISATIONS:

Haemorrhoids	yes no	Reason:	Year
Bladder infections	yes no	_____	
Kidney disease	yes no	_____	
Hay fever / sinusitis	yes no	_____	
Glaucoma	yes no	_____	
Nose bleeds	yes no	_____	
Bowel disease	yes no	_____	
Emotional illness	yes no	_____	
Other (describe)	yes no	_____	

X-RAYS & OTHER TESTS: Describe results:

Chest x-ray	yes no	_____
Stomach x-ray	yes no	_____
Bowel x-ray	yes no	_____
Gallbladder x-ray	yes no	_____
Kidney x-ray	yes no	_____
Electrocardiogram	yes no	_____
Other Tests that were abnormal:		_____

Year	Anemia	yes no	_____
	Bleeding tendency	yes no	_____
	Leukaemia	yes no	_____
	Repeated infections	yes no	_____
	Crippling infections	yes no	_____
	Heart disease	yes no	_____
	Chronic lung disease	yes no	_____
	Tuberculosis	yes no	_____
	High blood pressure	yes no	_____
	Kidney disease	yes no	_____
	Asthma	yes no	_____
	Severe allergies	yes no	_____
	Mental illness	yes no	_____
	Convulsions or fits	yes no	_____
	Migraine headaches	yes no	_____
Year	Diabetes	yes no	_____
	Low blood sugar	yes no	_____
	Obesity	yes no	_____
	Thyroid trouble	yes no	_____
	Peptic ulcer	yes no	_____
	Bowel disease	yes no	_____
	Cancer	yes no	_____
	Arthritis	yes no	_____
	Stroke	yes no	_____
	Gout	yes no	_____
Year	Birth defects	yes no	_____
	Other (describe)	yes no	_____

Family member:	Age if living:	Health problems? Age of death if deceased.
Grandparents:		
1.		
2.		
3.		
4.		
Father		
Mother		
Brothers/Sisters		
1.		
2.		
3.		
4.		
Spouse		
Children		
1.		
2.		
3.		
4.		

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'

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

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)

DIETARY HISTORY

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.

ENVIRONMENTAL FACTOR:	DESCRIBE YOUR REACTION OR SIGNIFICANT EXPOSURE NEXT TO THE FACTORS SELECTED.
<p>(<u>underline</u> the ones you react to)</p> <p>DUST House dust Other kind of dusts (road, wood, etc.)</p> <p>MOULDS Damp basements Old buildings/water damaged buildings Old barns, Old hay/straw Air conditioners Other:</p> <p>ANIMALS Dog/cat/horse/ other (describe)</p> <p>FEATHERS Feather pillows Birds</p> <p>POLLENS Trees Grasses Rag weed Country air Other pollens:</p> <p>SMOKE Wood smoke Tobacco smoke Other smoke:</p> <p>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:</p> <p>WEATHER Hot, muggy weather Damp or muggy weather Spring or fall weather Cold weather Approaching storms Change in location Other climactic effects:</p> <p>ELECTROMAGNETIC FIELDS Fluorescent lighting Computer monitors High-voltage transmission lines X-ray or nuclear radiation Other electromagnetic fields:</p> <p>DRUGS Aspirin, or other pain relievers Antibiotics Others (please describe)</p>	

MORE ON ENVIRONMENT AND HEALTH

1. Have you ever had allergy tests? yes no If so, what did they show? _____

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.

FOR EACH QUESTION PUT AN 'X' IN THE APPROPRIATE COLUMN ON THE RIGHT→	RARELY	SOME TIMES	OFTEN
1. Do you crave sweets or sugar-sweetened foods?			
2. How often do you eat sugar-sweetened foods?			
3. Did you eat a lot of sweets as a child?			
4. How often do you have coffee or tea or cola?			
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 you 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

Yeast overgrowth in the intestinal tract is a common problem affecting mood, energy, and immune function, yet it commonly goes unrecognised. Section A. lists factors in your medical history and section B. suggests symptoms commonly found in individuals with yeast -connected illness.

SECTION A: MEDICAL HISTORY- Circle the numbers on the right hand side for those questions which apply to you. (The last 3 questions apply to women only.)	POINT SCORE
Have you taken tetracyclines (or other antibiotics) for acne for two months or longer?	25
Have you, at any time in your life, taken other "broad spectrum" antibiotics for respiratory, urinary or other infections for a period of two months or longer, or in shorter courses 4 or more times in a 1-year period?	20
Have you taken prednisone, Decadron, or other cortisone type drugs... For more than two weeks? For two weeks or less?	15 6
Does exposure to perfumes, insecticides, fabric shop odours and other chemicals provoke... Moderate to severe symptoms? Mild symptoms?	20 5
Are your symptoms worse on damp, muggy days or in mouldy places?	5
Have you had persistent athlete's foot, "jock itch", or other chronic fungus infections of the skin or nails? If so, have such infections been..... Severe or persistent? Mild to moderate?	20 10
Do you crave sugar?	10
Do you crave breads?	10
Do you crave alcoholic beverages?	10
Does tobacco smoke really bother you?	10
Have you, at any time in your life, been troubled by persistent vaginal problems or had three or more episodes of vaginitis in one year?	25
Have you been pregnant..... 2 or more times? 1 time?	5 3
Have you taken birth control pills...For more than 2 years? For 6 months to 2 years?	15 8
ADD POINT SCORES TO GET TOTAL SCORE FOR SECTION A →	
SECTION B: MAJOR SYMPTOMS-For each symptom which is present, enter the following score in the right hand column: SEVERE or DISABLING -9 points, MODERATE- 6 points, MILD- 3 points	SCORE ↓
Fatigue, or feeling of being "drained"	
Feeling "spacey" or "unreal", or "brain fog", or poor memory	
Depression	
Numbness, burning or tingling	
Muscle aches	
Muscle weakness	
Pain and/or swelling in joints	
Abdominal pain	
Constipation	
Diarrhoea	
Bloating	
Loss of sexual feeling	
Troublesome vaginal discharge (women)	
Persistent vaginal infection or burning or itching (women)	
Endometriosis (women only: a pelvic disease. If you had it, you would recognise the name.)	
Painful periods (women)	
Pre-menstrual tension (women)	
Prostatitis (men only: infection or inflammation of the prostate)	
Impotence (men)	
ADD POINT SCORES TO GET TOTAL SCORE FOR SECTION B →	

EMOTIONAL AND SOCIAL FACTORS IN HEALTH

Thoughts & emotions are very powerful influences in health and healing, especially with chronic illness. This section of the questionnaire is designed to help explore some of these areas. Please provide further details to the questions, if you are willing. This section is not meant to be an invasion of privacy, however, and if there are some questions you prefer not to answer, please do give them some careful thought, but leave the answer spaces blank.

How well do you and the individuals you live with get along?

Live alone Very well Fairly well Poorly Very poorly

Do you feel that your home life is contributing to any of your physical or emotional health problems?

Yes, definitely To some extent Little, or not at all

What is your occupation, or regular daily activity? _____

How well satisfied are you with your work (i.e., your employment, schoolwork, or your regular daily activities)?

Quite satisfied Somewhat satisfied Not satisfied

How difficult do you find your fellow workers (or classmates) to get along with?

Not applicable (work alone, retired, unemployed)
 Very difficult Fairly difficult Fairly easy Very easy

Do you feel that your work (or regular daily activities) is contributing to any of your physical or emotional health problems?

Yes, definitely To some extent Little, or not at all

Do your days give you a feeling of being stressed? Rarely Sometimes Often

If so, elaborate:

Are there significant events in your past that still weigh upon you emotionally?

Yes, definitely; they a significant on-going stress Yes, but I am handling them well No, nothing significant

If so, elaborate:

How much time you spend each day, on the average, in activities that you find relaxing?

(Such as: reading, listening to music, relaxation exercises, walking, etc.)

How much time? Rarely Sometimes Often, _____ hours per day/week.

On the average, how many hours of sleep do you get per night? _____ hours

On the average, how many nights per week do you feel that you do not get enough sleep? _____ nights.

For what reasons? _____

Do you have a religious faith? Yes No

If so, please specify, and describe whether it has been of use to you in dealing with your health problems, or past stresses in your life:

Do those you live with have a religious faith? Yes No

If this is different than yours, please describe:

'Wholistic health' includes a person's spiritual nature as well as the physical, and seeks healing of all the relationships that exist within your life: within you, between you and the people in your life, between yourself and God. This kind of healing can go on even in the face of serious physical illness that will not go away. If you were to address this aspect of health and healing, what would be your first step?

This questionnaire examines many things we could be doing for our health. To address them all at once may seem overwhelming. However, we can work to balance, as sensibly as possible, the various demands, risks, costs and benefits one faces each day. To achieve good balance in my own life, I need to put more emphasis on.....