

JOHN F. COOMBS, B.Sc., M.D.
3 WALTER'S LANE, FALLBROOK, ONTARIO
Mailing address: P.O. Box 20090, Perth, Ontario, K7H 3M6
Telephone: (613) 267-2523 Fax: (613) 267-6216

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, they can be requested 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

(Directions to Fallbrook are on the other side of this page)

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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:	Year	OPERATIONS:	Year
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	_____	
Arthritis	yes no	INJURIES:	Year
Back trouble	yes no	Head	yes no
Bronchitis	yes no	Chest	yes no
Pneumonia	yes no	Abdomen	yes no
Pleurisy	yes no	Broken bones	yes no
Asthma	yes no	Back	yes no
Emphysema	yes no	Other (describe)	yes no
Rheumatic fever	yes no	_____	
High blood pressure	yes no	DRUG REACTIONS:	Year
Heart disease	yes no	Penicillin	yes no
Anaemia	yes no	Sulpha	yes no
Bleeding tendency	yes no	Foods	yes no
Blood transfusion	yes no	Cosmetics	yes no
Hepatitis (yellow jaundice)	yes no	Other drugs	yes no
Ulcer	yes no	(Describe) _____	
Haemorrhoids	yes no	_____	
Bladder infections	yes no	HOSPITALISATIONS:	Year
Kidney disease	yes no	Reason:	
Hay fever / sinusitis	yes no	_____	
Glaucoma	yes no	_____	
Nose bleeds	yes no	_____	
Bowel disease	yes no	_____	
Emotional illness	yes no	_____	
Other (describe)	yes no	_____	

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	_____
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	_____
Birth defects	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 <u>abnormal</u> :		_____

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.		
5.		
6.		
7.		
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? If so, describe: _____				
NOSE			GENTOURINARY				
Loss of smell	yes	no	Frequent urination (day)	yes	no		
Frequent colds	yes	no	Frequent urination (night)	yes	no		
Obstruction	yes	no	Feel need to urinate without much urine	yes	no		
Sinus congestion	yes	no	Unable to hold urine	yes	no		
Excess discharge	yes	no	Pain or burning of urination	yes	no		
Nose bleeds	yes	no	Blood in urine	yes	no		
MOUTH/ DENTAL			JOINTS/BONES/MUSCLE				
Canker sores	yes	no	Muscle cramps	yes	no		
Sore or bleeding gums	yes	no	Muscle weakness	yes	no		
Sore tongue	yes	no	Pain in joints	yes	no		
Any silver/mercury fillings? How many?	yes	no	Swollen joints	yes	no		
Any root canals?	yes	no	Stiffness	yes	no		
Other dental problems	yes	no	Deformity of joints	yes	no		
THROAT			NERVOUS SYSTEM				
Post nasal drainage	yes	no	Headaches	yes	no		
Soreness	yes	no	Dizziness	yes	no		
Hoarseness	yes	no	Fainting	yes	no		
BREAST			Convulsions or fits	yes	no		
Lumps	yes	no	Nervousness, anxiety	yes	no		
Discharge	yes	no	Sleeplessness, insomnia	yes	no		
HEART&LUNGS			Depression	yes	no		
Cough, persistent	yes	no	Memory loss	yes	no		
Sputum (phlegm)	yes	no	Change in sensation	yes	no		
Bloody sputum	yes	no	Poor co-ordination	yes	no		
Wheezing	yes	no	Weakness or paralysis	yes	no		
Chest pain or discomfort	yes	no	HORMONAL				
Pain on breathing	yes	no	Thyroid trouble	yes	no		
Difficulty breathing	yes	no	Adrenal trouble	yes	no		
Swelling of ankles	yes	no	Cortisone treatment	yes	no		
Bluish fingers or lips	yes	no	Diabetes	yes	no		
High blood pressure	yes	no	GYNAECOLOGY				
Palpitations, irregular heart beat	yes	no	Started menstruating at age _____		Date of last Pap test _____		
Vein trouble	yes	no	Interval between periods: _____ days		duration: _____ days		
USE OF HEALTH PROFESSIONALS			Flow: light normal heavy		Date of last period _____		
Date of last complete medical exam _____			Pain with periods? yes no mild severe		Number of pregnancies: _____		
During the past year, how many visits have you made to each of the following :			Number of births: _____		Number of miscarriages: _____		
____ Family doctor	____ Psychiatrist		Problems with vaginal discharge: ___yes ___no ___in past, not now				
____ Specialist doctor	____ Other counsellor		Premenstrual symptoms: ___ yes ___ no.				
____ Hospital emergency	____ Dentist		Describe: Mood changes Weight gain Retain fluid Cravings 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?			
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 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 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:

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	MODERATE	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