MAGNOLIA
Health Care

**YOUR KEY TO NATURAL HEALTH AND VITALITY**

# Assessment Forms

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Name: _____ Date: _____

CONTENTS

## 3-Day Diet Diary

Name: _____

It is important to keep an accurate record accurate record food and beverage intake as a part of your treatment plan. Please complete this Diet Diary for 3 consecutive days including one weekend day.

- Record information as soon as possible after the food has been consumed.
- Do not change your eating behavior at this time, as the purpose of this food record is to analyze your present eating habits
- Describe the food or beverage as accurately as possible e.g., milk- what kind? (Whole, 2%, nonfat); toast, (whole wheat, white, buttered); chicken (fried, baked, breaded); coffee (decaffeinated with sugar and cream).
- Record the amount of each food or beverage consumed using standard measurements such as 8 ounces, 1/2 cup, 1 teaspoon, etc.
- Include any added items. For example: tea with 1 teaspoon honey, potato with 2 teaspoons butter, etc.
- Record all beverages, including water, coffee, tea, sports drinks, sodas/diet sodas, etc.
- Include any additional comments about your eating habits on this form (ex. craving sweet, skipped meal and why, when the meal was at a restaurant, etc).
- Please note all bowel movements and their consistency (regular, loose, firm, etc.)

DIET DIARY

Name: _____ Date: _____

DAY 1

| TIME | FOOD/BEVERAGE/AMOUNT | COMMENTS |
|---|---|---|
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Bowel Movements (#, form, color) _____

Stress/Mood/Emotions _____

Other Comments _____

DAY2

| TIME | FOOD/BEVERAGE/AMOUNT | COMMENTS |
|---|---|---|
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Bowel Movements (#, form, color) _____

Stress/Mood/Emotions _____

Other Comments _____

DAY3

| TIME | FOOD/BEVERAGE/AMOUNT | COMMENTS |
|---|---|---|
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| | | |
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Bowel Movements (#, form, color) _____

Stress/Mood/Emotions _____

Other Comments _____

How Healthy Is Your Diet? Name: _____

Circle your answers after careful thought, then add up your points (numbers in parentheses).

1. **How many fruits do you *normally* eat each day (1/2 cup fresh or dried fruit, 1 medium piece, 1 cup *unsweetened* juice)?**
   A. 0 (-2)
   B. 1 (0)
   C. 2 to 3 (+2)
   D. 4 or more (+3) (score) _____

2. **How many vegetable servings do you *normally* eat each day (1 cup leafy greens, 1/2 cup any other veggie, raw or cooked)?**
   A. 0 (-4)
   B. 1 (0)
   C. 2 (+1)
   D. 3 (+2)
   E. 4 or more (+3) (score) _____

3. **How many different varieties of vegetables do you eat in a normal month?**
   A. 2 or less (-4)
   B. 3 to 4 (0)
   C. 5 to 6 (+1)
   D. 7 to 8 (+3)
   E. 9 or more (+4) (score) _____

4. **How many times do you eat dried beans or peas (legumes, lentils, chickpeas, kidney beans, green peas, etc.) in a normal week?**
   A. 0 (-2)
   B. 1 to 2 (0)
   C. 3 to 4 (+1)
   D. 5 to 6 (+2)
   E. 7 or more (+3) (score) _____

5. **How many times do you eat red meat in a normal week?**
   A. 6 or more (-4)
   B. 4 to 5 (-3)
   C. 1 to 3 (-1)
   D. Less than once a week (+2)
   E. 0 (+3) (score) _____

6. **How many times do you eat in a fast food restaurant in a normal week?**
   A. 6 or more (-5)
   B. 4 to 5 (-4)
   C. 1 to 3 (-3)
   D. Less than once a week (-2)
   E. 0 (0) (score) _____

7. **In a typical day, what do you drink *most* often?**
   A. Soda (regular or diet) (-4)
   B. Caffeinated coffee or tea (-1)
   C. Decaffeinated coffee or tea (0)
   D. Milk or fruit juice (0)
   E. Herbal tea or water (+3) (score) _____

8. **How many 12 oz. cans of soda do you drink in a normal day?**
   A. 6 or more (-5)
   B. 4 to 5 (-4)
   C. 2 to 3 (-3)
   D. 1 (-2)
   E. Less than 1 (-1)
   F. 0 (0) (score) _____

9. **How often do you eat fish in a typical week?**
   A. Never (-2)
   B. Once (+1)
   C. Twice (+2)
   D. 3 to 5 times (+3) (score) _____

10. **In a typical week, how often do you eat whole grains (100% whole grain bread, whole oats, brown rice, quinoa, whole rye crackers)?**
   A. Never (-3)
   B. 1 to 2 times a week (-1)
   C. 3 to 4 times a week (0)
   D. 5 to 6 times a week (+1)
   E. 1 or more times a day (+3) (score) _____

11. **How often do you eat sweets such as cookies, cakes, or ice cream?**
   A. 1 or more times a day (-3)
   B. Every other day (-2)
   C. Twice a week (-1)
   D. Once a week (0)
   E. 2 to 3 times a month (+1)
   F. Rarely (+3) (score) _____

**Your Total Score**_____

Scoring: **22–28** – Great eating habits

**17–21** – Pretty good eating habits

**10–16** – Needs some improvement

**9 or less** – Needs much improvement; try to change one habit at a time

# MEDICAL SYMPTOMS QUESTIONNAIRE

Name:_____ Date: _____

The Toxicity and Symptom Screening Questionnaire identifies symptoms that help to identify the underlying causes of illness, and helps you track your progress over time. Rate each of the following symptoms based upon your health profile for the past 30 days. If you are completing this after your first time, then record your symptoms for the last 48 hours ONLY.

POINT SCALE
0 = Never or almost never have the symptom
1 = Occasionally have the symptom, effect is not severe
2 = Occasionally have symptom, effect is severe
3 = Frequently have the symptom, effect is not severe
4 = Frequently have the symptom, effect is severe

DIGESTIVE TRACT
___ Nausea
___ Diarrhea
___ Constipation
___ Bloated feeling
___ Belching or passing gas
___ Heartburn
___ Intestinal/Stomach pain
*Total* _____

EARS
___ Itchy ears
___ Earaches or ear infections
___ Drainage from ear
___ Ringing in ears, hearing loss
*Total* _____

EMOTIONS
___ Mood swings
___ Anxiety, fear or nervousness
___ Anger, irritability or aggressiveness
___ Depression
*Total* _____

ENERGY/ACTIVITY
___ Fatigue, sluggishness
___ Apathy, lethargy
___ Hyperactivity
___ Restlessness
*Total* _____

EYES
___ Watery or itchy eyes
___ Swollen, reddened or sticky eyes
___ Bags or dark circles under eyes
___ Blurred or tunnel vision (does not include near or far-sightedness)
*Total* _____

HEAD
___ Headaches
___ Faintness
___ Dizziness
___ Insomnia
*Total* _____

HEART
___ Irregular or skipped heartbeat
___ Rapid or pounding heartbeat
___ Chest pain
*Total* _____

JOINTS/MUSCLES
___ Pain or aches in joints
___ Arthritis
___ Stiffness or limitation of movement
___ Pain or aches in muscles
___ Feeling of weakness or tiredness
*Total* _____

LUNGS
___ Chest congestion
___ Asthma, bronchitis
___ Shortness of breath
___ Difficult breathing
*Total* _____

MIND
___ Poor memory
___ Confusion, poor comprehension
___ Poor concentration
___ Poor physical coordination
___ Difficulty in making decisions
___ Stuttering or stammering
___ Slurred speech
___ Learning disabilities
*Total* _____

MOUTH/THROAT
___ Chronic coughing
___ Gagging, frequent throat clearing
___ Sore throat, hoarseness, loss of voice
___ Swollen, discolored tongue, gum, lips
___ Canker sores
*Total* _____

NOSE
___ Stuffy nose
___ Sinus problems
___ Hay fever
___ Sneezing attacks
___ Excessive mucus formation
*Total* _____

SKIN
___ Acne
___ Hives, rashes or dry skin
___ Hair loss
___ Flushing or hot flushes
___ Excessive sweating
*Total* _____

WEIGHT
___ Binge eating/drinking
___ Craving certain foods
___ Excessive weight
___ Compulsive eating
___ Water retention
___ Underweight
*Total* _____

OTHER
___ Frequent illness
___ Frequent or urgent urination
___ Genital itch or discharge
*Total* _____

GRAND TOTAL _____

**KEY TO QUESTIONNAIRE**
Add individual scores and total each group. Add the group scores and give a grand total.
• Optimal is less than 10. • Mild toxicity is 10 – 50. • Moderate toxicity is 50 – 100. • Severe toxicity is over 100

# BASAL BODY TEMPERATURE

**Basal Body Temperature**

Please shake down a thermometer at night before you go to bed. In the morning before you get out of bed, place the thermometer [CIRCLE ONE]:

(a) in your mouth, or

(b) in your armpit for ten minutes.

It is important that you remain in bed and as quiet and relaxed as possible for this period of time. Record the temperature on the chart below. Women should also record where they are in their menstrual cycle, i.e., "menstruating," "first half of cycle," or "second half of cycle."

**Day 1_____**

**Day 2_____**

**Day 3_____**

**Day 4_____**

**Day 5_____**

**Day 6_____**

**Day 7_____**

**Day 8_____**

**Day 9_____**

**Day 10_____**

**Day 11_____**

**Day 12_____**

**Day 13_____**

**Day 14_____**

# BPH Symptom Index

Name_____ Date_____

Circle the appropriate number for each question:

| | Not at all | Less than 1 time in 5 | Less than half the time | About half the time | More than half the time | Almost always |
|---|---|---|---|---|---|---|
| 1. During the last month or so, how often have you had a sensation of not emptying your bladder completely after your finished urinating? | 0 | 1 | 2 | 3 | 4 | 5 |
| 2. During the last month or so, how often have you had to urinate again less than 2 hours after you finished urinating? | 0 | 1 | 2 | 3 | 4 | 5 |
| 3. During the last month or so, how often have you found you stopped and started again several times when you urinated? | 0 | 1 | 2 | 3 | 4 | 5 |
| 4. During the last month or so, how often have you found it difficult to postpone urination? | 0 | 1 | 2 | 3 | 4 | 5 |
| 5. During the last month or so, how often have you had a weak urinary stream? | 0 | 1 | 2 | 3 | 4 | 5 |
| 6. During the last month or so, how often have you had to push or strain to begin urination? | 0 | 1 | 2 | 3 | 4 | 5 |
| 7. During the last month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning? | 0 | 1 | 2 | 3 | 4 | 5 or more |

Symptom score = sum of questions 1 to 7. Total

# Yeast Questionnaire - Adult

Answering these questions and adding up the scores will help you decide if yeasts contribute to your health problems. Yet you will not obtain an automatic "yes" or "no" answer. For each "yes" answer in Section A, circle the point score in that section. Total your score and record it at the end of the section. Then move on to sections B and C and score as indicated. Add the total of your scores to get your Grand Total Score.

**Section A: History**

| | Point score |
|---|---|
| Minocin, etc.) or other antibiotics for acne for one month (or longer)? | 35 |
| 2. Have you, at any time in your life, taken other "broad spectrum" antibiotics* for respiratory, urinary, or other infections (for two months or longer, or in shorter courses four or more times in a one-year period)? | 35 |
| 3. Have you taken a broad spectrum antibiotic drug*, even a single course? | 6 |
| 4. Have you, at any time in your life, been bothered by persistent prostatitis, vaginitis, or other problems affecting your reproductive organs? | 25 |
| | |
| 5. Have you been pregnant | |
| Two or more times? | 5 |
| One time? | 3 |
| 6. Have you taken birth control pills | |
| For more than two years? | 15 |
| For six months to two years? | 8 |
| 7. Have you taken prednisone, Decadrong or other cortisone-type drugs | |
| For more than two weeks? | 15 |
| For two weeks or less? | 6 |
| 8. Does exposure to perfumes, insecticides, fabric shop odors, and other chemicals provoke | |
| Moderate to severe symptoms? | 20 |
| Mild symptoms? | 5 |
| 9. Are your symptoms worse on damp, muggy days or in moldy places? | 20 |
| 10. Have you had athlete's foot, ringworm, "jock itch," or other chronic fungus infections of the skin or nails? Have such infections been | |
| Severe or persistent? | 20 |
| Mild to moderate? | 10 |
| 11. Do you crave sugar? | 10 |
| 12. Do you crave breads? | 10 |
| 13. Do you crave alcoholic beverages? | 10 |
| 14. Does tobacco smoke really bother you? | 10 |
| | |
| Total Score, Section A | |

* Including Keflex, ampicillin, amoxicillin, Ceclor, Bactrim, and Septra. Such antibiotics kill off "good germs" while they're killing off those which cause infection.

**Section B: Major Symptoms**
For each of your symptoms, enter the appropriate figure in the Point Score column:

If a symptom is occasional or mild score 3 points
If a symptom is frequent and/or moderately severe score 6 points
If a symptom is severe and/or disabling score 9 points
Add total score and record it at the end of this section.

| | Point score |
|---|---|
| 1. Fatigue or lethargy | |
| 2. Feeling of being "drained" | |
| 3. Poor memory | |
| 4. Feeling "spacey" or "unreal" | |
| 5. Depression | |
| 6. Inability to make decisions | |
| 7. Numbness, burning, or tingling | |
| 8. Muscle aches or weakness | |
| 9. Pain and/or swelling in joints | |
| 10. Abdominal pain | |
| 11. Constipation | |
| 12. Diarrhea | |
| 13. Bloating, belching, or intestinal gas | |
| 14 Troublesome vaginal burning, itching, or discharge | |
| 15. Persistent vaginal burning or itching | |
| 16. Prostatitis | |
| 17. Impotence | |
| 18. Loss of sexual desire or feeling | |
| 19. Endometriosis or infertility | |
| 20. Cramps and/or other menstrual irregularities | |
| 21. Premenstrual tension | |
| 22. Attacks of anxiety or crying | |
| 23. Cold hands or feet and/or chilliness | |
| 24. Shaking or irritable when hungry | |
| Total Score, Section B..... | |

**Section C: Other Symptoms**[*]

For each of your symptoms, enter the appropriate figure in the point score column:

If a symptom is occasional or mild score 1 point

If a symptom is frequent and/or moderately severe score 2 points

If a symptom is severe and/or disabling score 3 points

Add total score and record it at the end of this section.

| | Point score |
|---|---|
| 1. Drowsiness | |
| 2. Irritability or jitteriness | |
| 3. Uncoordination | |
| 4. Inability to concentrate | |
| 5. Frequent mood swings | |
| 6. Headache | |
| 7. Dizziness/loss of balance | |
| 8. Pressure above ears, feeling of head swelling | |
| 9. Tendency to bruise easily | |
| 10. Chronic rashes or itching | |
| 11. Numbness, tingling | |
| 12. Indigestion or heartburn | |
| 13. Food sensitivity or intolerance | |
| 14. Mucus in stools | |
| 15. Rectal itching | |
| 16. Dry mouth or throat | |
| 17. Rash or blisters in mouth | |
| 18. Bad breath | |
| 19. Foot, body, or hair odor not relieved by washing | |
| 20. Nasal congestion or postnasal drip | |
| 21. Nasal itching | |
| 22. Sore throat | |
| 23. Laryngitis, loss of voice | |
| 24. Cough or recurrent bronchitis | |
| 25. Pain or tightness in chest | |
| 26. Wheezing or shortness of breath | |
| 27. Urgency or urinary frequency | |
| 28. Burning on urination | |
| 29. Spots in front of eyes or erratic vision | |
| 30. Burning or tearing of eyes | |
| 31. Recurrent infections or fluid in ears | |
| 32. Ear pain or deafness | |
| Total Score, Section C ..... | |
| Total Score, Section A ..... | |
| Total Score, Section B ..... | |
| GRAND TOTAL SCORE ..... | |

The Grand Total Score will help you and your physician decide if your health problems are yeast connected. Scores in women will run higher as seven items in the questionnaire apply exclusively to women, while only two apply exclusively to men.

Yeast-connected health problems are almost certainly present in women with scores over 180 and in men with scores over 140.

Yeast-connected health problems are probably present in women with scores over 120 and in men with scores over 90.

Yeast-connected health problems are possibly present in women with scores over 60 and in men with scores over 40.

With scores of less than 60 in women and 40 in men, yeasts are less apt to cause health problems.

[*] While the symptoms in this section commonly occur in people with yeast-connected illness, they are also found in other individuals

## CFIDS CDC Definition Criteria

Patient Name_____ Date_____

*Major Criteria:*

_____ Fatigue: new onset
_____ Exclusion of other clinical conditions

*Minor Criteria:*

Symptoms (a symptom must have begun at or after time of fatigue onset, and persisted or recurred over 6 months)

_____ Mild fever or chills
_____ Sore throat
_____ Painful lymph nodes (ant. or post cerv. or axillary)
_____ Generalized muscle weakness
_____ Myalgia or muscle discomfort
_____ Prolonged generalized fatigue after exercise
_____ Generalized, new headaches
_____ Migratory arthralgia
_____ Neuropsychologic complaints
_____ Sleep disturbance
_____ Abrupt onset of main symptom complex

Physical (documented by a physician on at least 2 occasions, at least one month apart)

_____ Low grade fever
_____ Nonexudative pharyngitis
_____ Palpable or tender nodes (ant. or post cerv. or axillary)

*Fulfills:*

_____ Major criteria _____ > 8 Symptom criteria
_____ 6 Symptom criteria and > 2 Physical criteria

*Assessment:* _____ FITS CDC CRITERIA_____DOES NOT FIT CDC CRITERIA

# Colon Transit Time

**Name**:_____ **Date**:_____ **Baseline**:_____ **Follow-up**:_____

One of the most common health hazards and problems in Western civilization is chronic constipation and disease of the colon, e.g., hemorrhoids, diverticulitis, colitis, cancer of the colon, and auto-toxicity (self-poisoning) from chronic constipation.

Studies of other cultures have consistently shown the correlation between healthy colons, large stools, and normal colon transit time. African and Asian natives from rural communities who eat bulky, high-fiber diets with little or no meat and no refined foods have almost complete freedom from heart disease, atherosclerosis, cancer (especially of the colon and rectum), diabetes, appendicitis, mental disease, and hypoglycemia.

In addition to the consistency and frequency of bowel movements, a measure of colon health is the COLON TRANSIT TIME. This is done simply by eating a moderate serving of corn or beets or taking activated charcoal capsules and observing their appearance in the stool.

**DIRECTIONS:**
**PLEASE USE THIS SHEET AS YOUR WORKSHEET, AND SUBMIT IT TO YOUR HEALTH PRACTITIONER WHEN COMPLETE.**

A. Consume a moderate serving (1/2 to 3/4 cup) of corn or beets or four charcoal capsules.
Date:_____ Exact Time:_____

B. Visually examine stool (bowel movements), and note when corn or beets or charcoal is first seen. (beets are seen as a redness in stool color, charcoal will turn the stool black and corn is seen as whole corn.)
Date:_____ Exact Time:_____

C. Note time when corn or beets or charcoal is last seen in stool.
Date:_____ Exact Time:_____

D. On a typical day, how often do you move your bowels and are they formed or loose or somewhere in between? Please describe.

_____

_____

The time between when you ingested the corn, beets or charcoal to the time it first appears in your stool and stops appearing in your stool is your bowel transit time range. People living in rural African and Asian societies have a colon transit time of between 12 to 24 hours. In our culture, the average colon transit time is much longer. If a long transit time is found, it indicates suboptimal colon health. If a very rapid transit time is found, it may indicate poor absorption and assimilation of nutrients. Both conditions need treatment and correction.

## Depression Anxiety Stress Scales

The DASS is a 42-item self report instrument designed to measure the three related negative emotional states of depression, anxiety and tension/stress.

**How do I get permission to use the DASS?**

The DASS questionnaire is public domain, and so permission is not needed to use it. The DASS questionnaires and scoring key may be downloaded from the DASS website and copied without restriction (go to http://www2.psy.unsw.edu.au/Groups/Dass/down.htm).

The DASS questionnaires and scoring key may also be distributed, published or made available electronically, with the restrictions that:

a) the scales are not modified,

b) the scales are not sold for profit,

c) the intended audience is researchers or health professionals rather than end users, and

reference is included to the DASS website: www.psy.unsw.edu.au/dass/

DAS *Name:* *Date:*

Please read each statement and circle a number 0, 1, 2 or 3 that indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

*The rating scale is as follows:*

0 Did not apply to me at all

1 Applied to me to some degree, or some of the time

2 Applied to me to a considerable degree, or a good part of time

3 Applied to me very much, or most of the time

| | | | | | |
|---|---|---|---|---|---|
| 1 | I found myself getting upset by quite trivial things | 0 | 1 | 2 | 3 |
| 2 | I was aware of dryness of my mouth | 0 | 1 | 2 | 3 |
| 3 | I couldn't seem to experience any positive feeling at all | 0 | 1 | 2 | 3 |
| 4 | I experienced breathing difficulty (e.g., excessively rapid breathing, breathlessness in the absence of physical exertion) | 0 | 1 | 2 | 3 |
| 5 | I just couldn't seem to get going | 0 | 1 | 2 | 3 |
| 6 | I tended to over-react to situations | 0 | 1 | 2 | 3 |
| 7 | I had a feeling of shakiness (e.g., legs going to give way) | 0 | 1 | 2 | 3 |
| 8 | I found it difficult to relax | 0 | 1 | 2 | 3 |
| 9 | I found myself in situations that made me so anxious I was most relieved when they ended | 0 | 1 | 2 | 3 |
| 10 | I felt that I had nothing to look forward to | 0 | 1 | 2 | 3 |
| 11 | I found myself getting upset rather easily | 0 | 1 | 2 | 3 |
| 12 | I felt that I was using a lot of nervous energy | 0 | 1 | 2 | 3 |
| 13 | I felt sad and depressed | 0 | 1 | 2 | 3 |
| 14 | I found myself getting impatient when I was delayed in any way (e.g., elevators, traffic lights, being kept waiting) | 0 | 1 | 2 | 3 |
| 15 | I had a feeling of faintness | 0 | 1 | 2 | 3 |
| 16 | I felt that I had lost interest in just about everything | 0 | 1 | 2 | 3 |
| 17 | I felt I wasn't worth much as a person | 0 | 1 | 2 | 3 |
| 18 | I felt that I was rather touchy | 0 | 1 | 2 | 3 |
| 19 | I perspired noticeably (e.g., hands sweaty) in the absence of high temperatures or physical exertion | 0 | 1 | 2 | 3 |
| 20 | I felt scared without any good reason | 0 | 1 | 2 | 3 |
| 21 | I felt that life wasn't worthwhile | 0 | 1 | 2 | 3 |

*Please turn the page* ☞

**DASS 42 SCORE SHEET**

*Reminder of rating scale:*

0 Did not apply to me at all

1 Applied to me to some degree, or some of the time

2 Applied to me to a considerable degree, or a good part of time

3 Applied to me very much, or most of the time

| | | | | | |
|---|---|---|---|---|---|
| 22 | I found it hard to wind down | 0 | 1 | 2 | 3 |
| 23 | I had difficulty in swallowing | 0 | 1 | 2 | 3 |
| 24 | I couldn't seem to get any enjoyment out of the things I did | 0 | 1 | 2 | 3 |
| 25 | I was aware of the action of my heart in the absence of physical exertion (e.g., sense of heart rate increase, heart missing a beat) | 0 | 1 | 2 | 3 |
| 26 | I felt down-hearted and blue | 0 | 1 | 2 | 3 |
| 27 | I found that I was very irritable | 0 | 1 | 2 | 3 |
| 28 | I felt I was close to panic | 0 | 1 | 2 | 3 |
| 29 | I found it hard to calm down after something upset me | 0 | 1 | 2 | 3 |
| 30 | I feared that I would be "thrown" by some trivial but unfamiliar task | 0 | 1 | 2 | 3 |
| 31 | I was unable to become enthusiastic about anything | 0 | 1 | 2 | 3 |
| 32 | I found it difficult to tolerate interruptions to what I was doing | 0 | 1 | 2 | 3 |
| 33 | I was in a state of nervous tension | 0 | 1 | 2 | 3 |
| 34 | I felt I was pretty worthless | 0 | 1 | 2 | 3 |
| 35 | I was intolerant of anything that kept me from getting on with what I was doing | 0 | 1 | 2 | 3 |
| 36 | I felt terrified | 0 | 1 | 2 | 3 |
| 37 | I could see nothing in the future to be hopeful about | 0 | 1 | 2 | 3 |
| 38 | I felt that life was meaningless | 0 | 1 | 2 | 3 |
| 39 | I found myself getting agitated | 0 | 1 | 2 | 3 |
| 40 | I was worried about situations in which I might panic and make a fool of myself | 0 | 1 | 2 | 3 |
| 41 | I experienced trembling (e.g., in the hands) | 0 | 1 | 2 | 3 |
| 42 | I found it difficult to work up the initiative to do things | 0 | 1 | 2 | 3 |

Enter each score from the questionnaire into the first two columns.

Add up each row and enter the score into the available box (D, A or S)

Add up the each of the D, A and S columns.

The total for each column is the score for that trait:

D = Depression

A = Anxiety

S = Stress

Use the ratings table below to assess the meaning of each score.

| Q | Score | Q | Score | All D scores | All A scores | All S Scores |
|---|---|---|---|---|---|---|
| 1 | | 22 | | | | |
| 2 | | 23 | | | | |
| 3 | | 24 | | | | |
| 4 | | 25 | | | | |
| 5 | | 26 | | | | |
| 6 | | 27 | | | | |
| 7 | | 28 | | | | |
| 8 | | 29 | | | | |
| 9 | | 30 | | | | |
| 10 | | 31 | | | | |
| 11 | | 32 | | | | |
| 12 | | 33 | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| 13 | | 34 | | | | |
| 14 | | 35 | | | | |
| 15 | | 36 | | | | |
| 16 | | 37 | | | | |
| 17 | | 38 | | | | |
| 18 | | 39 | | | | |
| 19 | | 40 | | | | |
| 20 | | 41 | | | | |
| 21 | | 42 | | | | |
| | | | | | | |
| | | | | Total for D | Total for A | Total for S |

| **Interpretation** | Depression (D) | Anxiety (A) | Stress (S) |
|---|---|---|---|
| Normal | 0-9 | 0-7 | 0-14 |
| Mild | 10-13 | 8-9 | 15-18 |
| Moderate | 14-20 | 10-14 | 19-25 |
| Severe | 21-27 | 15-19 | 26-33 |
| Extremely Severe | >28 | >20 | >34 |

DAS S Scoring Template

S
A
D
A

D
S
A
S
A

D
S
S
D
S

A
D
D
S
A

A
D

Apply template to both sides of sheet and sum scores for each scale.
For short (21-item) version, multiply sum by 2.

## Environmental Sensitivity Questionnaire

Name:

Do you have or use any of the following at/near home or work?

| Exposure: | Home | Work | Exposure | Home | Work |
|---|---|---|---|---|---|
| a. Spring water | | | u. Foam rubber pillows | | |
| b. Well water | | | v. Feather/down Comforter | | |
| c. Water purifier | | | w. Coat/jacket | | |
| d. Damp cellar | | | x. Stuffed upholstery | | |
| e. Wooded area | | | y. Animals | | |
| f. Swamp | | | z. Polyester blend in: Sheets | | |
| g. Power lines | | | aa. Pillow case | | |
| h. Microwave transmitter | | | ab. Pajamas | | |
| i. Smoke stacks | | | ac. Shirts | | |
| j. Dump | | | ad. Skirts | | |
| k. Gas stove | | | ae. Pants | | |
| l. Gas furnace | | | af. Exterminator | | |
| m. Gas hot water heater | | | ag. Moth balls | | |
| n. Gas dryer | | | ah. Mold on: Shower curtain | | |
| o. Wood stove | | | ai. Basement walls | | |
| p. Coal stove | | | aj. First story walls | | |
| q. Kerosene space heater | | | ak. Second story walls | | |
| r. Forced hot air heat | | | al. Garage under living space | | |
| s. Electric blankets | | | am. Urea formaldehyde insulation | | |
| t. Feather pillows | | | an. Other: | | |

- Are you bothered by: (check appropriate selections)

| | | | |
|---|---|---|---|
| a. Gasoline fumes | | l. Fabric stores | |
| b. Diesel exhaust | | m. New car smell | |
| c. Soaps | | n. Air conditioners | |
| d. Detergents | | o. Newsprint | |
| e. Chlorinated water | | p. Tobacco smoke | |
| f. Moth balls | | q. Cats | |
| g. Asphalt/tar | | r. Dogs | |
| h. Hair spray | | s. Mold | |
| i. Cosmetics | | t. Tree pollen | |
| j. Perfume | | u. Grass pollen | |
| k. Dust | | v. Ragweed pollen | |

- Please check appropriate selections about carpeting in your home.

| | **BEDROOM** | √ | | **LIVING ROOM** | √ | | **FAMILY ROOM** | √ |
|---|---|---|---|---|---|---|---|---|
| a. | None | | h. | None | | r. | None | |
| b. | Area rugs | | i. | Area rugs | | s. | Area rugs | |
| c. | Wall to wall | | j. | Wall to wall | | t. | Wall to wall | |
| d. | Wool | | k. | Wool | | u. | Wool | |
| e. | Synthetic pad | | l. | Synthetic pad | | v. | Synthetic pad | |
| f. | Glued down | | m. | Glued down | | w. | Glued down | |
| g. | How old is carpeting? | | n. | How old is carpeting? | | x. | How old is carpeting? | |
| | | | o. | On slab | | y. | On slab | |
| | | | p. | Ever damp? | | z. | Ever damp? | |
| | | | q. | Moldy | | aa. | Moldy | |

# Fibromyalgia Impact Questionnaire

Name_____ Date_____

Directions: For questions 1 through 11, please circle the number that best describes how you did **overall** for the past week. If you don't normally do something that is asked, cross the question out.

| Were you able to: | Always | Most | Occasionally | Never |
|---|---|---|---|---|
| 1. Do Shopping? | 0 | 1 | 2 | 3 |
| 2. Do laundry with a washer and dryer? | 0 | 1 | 2 | 3 |
| 3. Prepare meals? | 0 | 1 | 2 | 3 |
| 4. Wash dishes/cooking utensils by hand? | 0 | 1 | 2 | 3 |
| 5. Vacuum a rug? | 0 | 1 | 2 | 3 |
| 6. Make beds? | 0 | 1 | 2 | 3 |
| 7. Walk several blocks? | 0 | 1 | 2 | 3 |
| 8. Visit friends or relatives? | 0 | 1 | 2 | 3 |
| 9. Do yard work? | 0 | 1 | 2 | 3 |
| 10. Drive a car? | 0 | 1 | 2 | 3 |
| 11. Climb stairs? | 0 | 1 | 2 | 3 |

12. Of the 7 days in the past week, how many days did you feel good?

0 1 2 3 4 5 6 7

13. How many days last week did you miss work, including housework, because of fibromyalgia?

0 1 2 3 4 5 6 7

***PLEASE TURN PAGE OVER AND COMPLETE SIDE 2.***

**Directions:** For the remaining items, mark the point on the line that best indicates how you felt **overall** for the past week?

14. When you worked, how much did pain or other symptoms of your fibromyalgia interfere with your ability to do your work, including housework?

♦ ♦

No problem with work — Great difficulty with work

15. How bad has your pain been?

♦ ♦

No pain — Very severe pain

16. How tired have you been?

♦ ♦

No tiredness — Very tired

17. How have you felt when you get up in the morning?

♦ ♦

Awoke rested — Awoke very tired

18. How bad has your stiffness been?

♦ ♦

No stiffness — Very stiff

19. How nervous or anxious have your felt?

♦ ♦

Not anxious — Very anxious

20. How depressed or blue have you felt?

♦ ♦

Not depressed — Very depressed

| FIBROMYALGIA IMPACT QUESTIONNAIRE (FIQ) | Name: |
|---|---|

The Fibromyalgia Impact Questionnaire (FIQ) is an instrument designed to quantitate the overall impact of fibromyalgia over many dimensions (e.g. function, pain level, fatigue, sleep disturbance, psychological distress etc.). It is scored from 0 to 100 with the latter number being the worst case. The average score for patients seen in tertiary care settings is about 50. The FIQ is widely used to assess change in fibromyalgia status and has been translated into 12 languages.

The FIQ is free. You may use the FIQ without asking permission, but it is expected that you will reference it in any publication.

The reference is: *Burckhardt, C.S., Clark, S.R., Bennett, R.M.: The fibromyalgia impact questionnaire (FIQ): development and validation. J Rheumatol. 18:728-733, 1991.*

We provide the FIQ and its Scoring in PDF format in the following 2 files:

**Fibromyalgia Impact Questionnaire (FIQ)**

**Scoring for FIQ – Link to the pdf**

A list of FIQ references (in HTML format) can be found at **References**

**Fibromyalgia Impact Questionnaire (FIQ): Description and Scoring**

The FIQ is an assessment and evaluation instrument developed to measure fibromyalgia (FM) patient status, progress and outcomes. It has been designed to measure the components of health status that are believed to be most affected by FM.

**Content**

The FIQ is composed of 10 items. The first item contains 11 questions related to physical functioning – each question is rated on a 4 point Likert type scale. Items 2 and 3 ask the patient to mark the number of days they felt well and the number of days they were unable to work (including housework) because of fibromyalgia symptoms. Items 4 through 10 are horizontal linear scales marked in 10 increments on which the patient rates work difficulty, pain, fatigue, morning tiredness, stiffness, anxiety and depression.

**Administration**

The FIQ is a self administered instrument that takes approximately 5 minutes to complete. The directions are simple and the scoring is self-explanatory.

**Scoring**

The FIQ is scored in such a way that a higher score indicates a greater impact of the syndrome on the person. Each of the 10 items has a maximum possible score of 10. Thus the maximum possible score is 100. The average FM patient scores about 50, severely afflicted patients are usually 70 plus. The questionnaire is scored in the following manner:

1. The first item consists of 11 questions that make up a physical functioning scale. The 11 questions are scored and summed to yield one physical impairment score. Each item is rated on a 4 point Likert type scale. Raw scores on each item can range from 0 (always) to 3 (never) - thus the highest total possible raw score is 33. Because some patients may not do some of the tasks listed, they are given the option of deleting items from scoring. In order to obtain a valid summed score for questions 1 through 11, the scores for the items that the patient has rated are summed and divided by the number of items rated (e.g. if the patient completed only 9 items at a score of 2 for each, the final score would be 9x2/9= 2). An average raw score between 0 and 3 is obtained in this manner.

2. Item 2 is scored inversely - so that a higher number indicates impairment (i.e., 0=7, 1=6, 2=5, 3=4, 4=3, 5=2, 6=1 and 7=0, etc.). Raw scores can range from 0 to 7.

3. Item 3 is scored directly (i.e. 7=7 and 0=0). Raw scores can range from 0 to 7.

4. Items 4 through 10 are scored in 10 increments .Raw scores can range from 0 to 10. 1f the patient marks the space between two vertical lines on any item, that item is given a score that includes 0.5.

5. Once the initial scoring has been completed, the resulting scores are subjected to a normalization procedure so that all scores are expressed in similar units. The range of normalized scores is 0 to 10 with 0 indicating no impairment and 10 indicating maximum impairment.

| Scale | Item # | Recode | Score Range | Normalization |
|---|---|---|---|---|
| Physical impairment | 1 | No | 0-3 | S X 3.33 |

| | | | | |
|---|---|---|---|---|
| Feel good | 2 | Yes | 0-7 | S X 1.43 |
| Work missed | 3 | No | 0-7 | S X 1.43 |
| Do work | 4 | No | 0-10 | None |
| Pain | 5 | No | 0-10 | None |
| Fatigue | 6 | No | 0-10 | None |
| Rested | 7 | No | 0-10 | None |
| Stiffness | 8 | No | 0-10 | None |
| Anxiety | 9 | No | 0-10 | None |
| Depression | 10 | No | 0-10 | None |

In order to maintain a maximum possible score of 100 it is necessary to employ an "equalization calculation" if a patient does not answer all 10 items. If one or more items are missed, the final summative score needs to by multiplied by 10/x. (e.g. if one question is missed multiply by 10/9 [i.e. 1.111], if 2 questions are missed multiply by 10/8 [i.e. 1.25 etc.] )

**Addendum**

When the first version of the FIQ was developed, patients who were not working outside the home, were asked to skip the 2 questions regarding work. Therefore, a total score was made from the remaining 8 items. Since the revision of 1997 (unpublished), the work items have included housework so that all patients could potentially answer the work questions. Researchers over the years have used either 8 items or 10 items to form the total score. Users of the FIQ should indicate in their publications whether they used the 8-item method of deriving a total score or all 10 items. If they use the 8 item version they should multiply the total FIQ score by 10/8 (i.e. 1.25) so that results can be compared across studies.

**Translations**

The FIQ has been translated into at least 16 languages of which we are aware. These include: Swedish, Norwegian, Icelandic, Danish, Portuguese (Brazil, Portugal), Hebrew, Spanish (Spain, Mexico, Argentina, Cuba), German, Farsi, Arabic and French (France and Canada),Greek, Italian, Korean, Dutch and Turkish. Most of these translations have been validated.

**FIQ *Citation***

*Burckhardt, C.S., Clark, S.R, & Bennett, RM. (1991). The Fibromyalgia Impact Questionnaire: Development and validation. Journal of Rheumatology, 18, 728-734*

## Symptoms Associated with Hormone Imbalances

Questionnaire to be administered and scored by clinician

**0 = no symptoms 1= mild 2 = moderate 3 = severe**
**▲E = estrogen ▲P = progesterone ▲T = testosterone ▲C= Cortisol ▲TH = thyroid**

| Date: | Hormone Relationship | Patient Symptom Score | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | ↑E | ↓E | ↑P | ↓P | ↑T | ↓T | ↑C | ↓C | ↑TH | ↓TH |
| **Anxiety** | **↑E ↓P ↓T ↑C ↓TH** | | | | | | | | | | |
| **Arthritis** | **↓T ↓P** | | | | | | | | | | |
| **Bladder symptoms** | **↓E ↓T** | | | | | | | | | | |
| **♀Breakthrough bleeding** | **↓P** | | | | | | | | | | |
| **Breast tenderness** | **↑E ↓P** | | | | | | | | | | |
| **Cold hands and feet** | **↓C ↓TH** | | | | | | | | | | |
| **Constipation** | **↓TH** | | | | | | | | | | |
| **Cramps or painful periods** | **↓P ↓TH** | | | | | | | | | | |
| **Decreased enjoyment of life** | **↑E ↓P ↓T** | | | | | | | | | | |
| **Decreased immunity / recovery** | **↓C** | | | | | | | | | | |
| **Decreased strength or endurance** | **↓T ↓TH** | | | | | | | | | | |
| **Decreased sex drive** | **↑↓E ↓P ↓T ↑↓C ↓TH** | | | | | | | | | | |
| **Decreased ability to play sport** | **↓T ↓TH** | | | | | | | | | | |
| **Decrease in work performance** | **↓E ↓T ↓P ↓TH** | | | | | | | | | | |
| **Depression** | **↑↓P ↑C ↓E ↑↓T ↓TH** | | | | | | | | | | |
| **Dry skin/ hair** | **↓E ↓TH** | | | | | | | | | | |
| **Early-onset peri-menopause** | **↓E ↓C** | | | | | | | | | | |
| **Elevated LDL cholesterol** | **↓TH** | | | | | | | | | | |
| **♂Erectile dysfunction** | **↓T** | | | | | | | | | | |
| **Fatigue** | **↑P ↓TH ↓T ↑↓C ↑↓E** | | | | | | | | | | |
| **Fibrocystic breast** | **↑E ↓P** | | | | | | | | | | |
| **Fluid retention** | **↑E ↓P** | | | | | | | | | | |
| **Harder to reach climax** | **↓T ↓E ↓P** | | | | | | | | | | |
| **Hair loss** | **↑T ↑↓TH ↑↓E ↑↓P ↑C** | | | | | | | | | | |
| **Headaches** | **↑↓E ↑↓P ↓T ↑C ↓TH** | | | | | | | | | | |
| **♀Heavy/ irregular menses** | **↑E ↓P ↓TH** | | | | | | | | | | |
| **Hoarseness (unexplained)** | **↓TH** | | | | | | | | | | |
| **Hot flashes** | **↑↓E ↓P ↓T** | | | | | | | | | | |
| **Irritability** | **↑E ↑↓P ↑T ↓C** | | | | | | | | | | |
| **Loss of memory** | **↑↓E ↑↓P ↓T ↑C ↓TH** | | | | | | | | | | |
| **Loose stools** | **↑C ↑TH** | | | | | | | | | | |
| **Low blood pressure** | **↓C** | | | | | | | | | | |
| **Muscle problems (pain, burning)** | **↓TH** | | | | | | | | | | |
| **Night sweats** | **↑↓C ↓E** | | | | | | | | | | |
| **Mood swings** | **↑E ↓P** | | | | | | | | | | |
| **Sleep disturbance** | **↑↓T ↓P ↓E ↑C** | | | | | | | | | | |
| **♀Vaginal dryness** | **↓E ↓T** | | | | | | | | | | |
| **Weakness/ muscular** | **↓T ↓P** | | | | | | | | | | |
| **Weight gain** | **↑E ↓P ↓TH** | | | | | | | | | | |
| **Weight loss** | **↑C ↑TH** | | | | | | | | | | |
| | **Totals** | | | | | | | | | | |

## HPA Axis Questionnaire

Name:

Please score only the items **you experience** on a scale of 1-4:

1 (This is a **mild** problem)
2 (This is a **significant** problem)
3 (This is a **major** problem)
4 (This is a **severe** problem)

1. ____ Lethargic Depression
2. ____ Excessive Need for Sleep
3. ____ Chronic Fatigue Syndrome
4. ____ Chronic Pain
5. ____ Fibromyalgia (musculoskeletal tender points)*
6. ____ Dizziness when you stand or bend
7. ____ Low blood pressure and/or drop of blood pressure on standing*
8. ____ Craving salty foods-pretzels, pickles etc.
9. ____ Poor wound healing*
10. ____ Easy bruising
11. ____ Fatigue
12. ____ Inability to handle even slight stresses
13. ____ Hypoglycemia: dizzy, irritable, or sleepy if you go without food for 4-5 hours; symptoms relieved by food
14. ____ Scars, elbows, nipples, or skin near nails that are unusually dark*
15. ____ Slow healing of cuts*
16. ____ Unstable body temperatures (hot or cold)
17. ____ Agitated Depression
18. ____ Weight gain around your abdomen, back of neck, and in the face and cheeks*
19. ____ Stretch marks-not from weight loss *
20. ____ Adult onset diabetes
21. ____ Osteoporosis
22. ____ Craving sweets
23. ____ Trouble falling or staying asleep
24. ____ Excessive dark male pattern hair growth (women)*
25. ____ Irregular or no periods (not menopausal)
26. ____ Eastern European heritage

**HPA Axis Questionnaire: Practitioner Interpretive Key**

The goal of this intake sheet is to obtain and collate data that will give you an idea of the presence and type of HPA axis dysfunction in your patient. These symptoms and signs are primarily a compilation from the *Williams Textbook of Endocrinology*-11th edition, as well as recent literature, and lastly, clinical experience. There are three sections divided by lines. Section 1 is correlated with low cortisol states, section 2 with high cortisol states, and section 3 with adrenal hyperplasia. Items with an asterisk should be assessed by physical examination.

Instructions:

Add up the patient's totals for each section. Enter them below over the highest possible score for each section. The totals will indicate which areas to focus on. There is no absolute cutoff to use, rather there is a continuum between normal and dysfunction. Use this information in conjunction with blood testing and salivary cortisol testing.

Low cortisol state _____/64
Elevated cortisol state _____/28
Adrenal hyperplasia _____/12

# Short Quality of Life Questionnaire for Inflammatory Bowel Disease

Name _____ Date_____

*This questionnaire is designed to find out how you have been feeling during the last 2 weeks. You will be asked about symptoms you have been having as a result of your inflammatory bowel disease, the way you have been feeling in general, and how your mood has been. Please circle the number of your choice below each question.*

1. How often has the feeling of fatigue or being tired and worn out been a problem for you during the past 2 weeks?
    1. All of the time
    2. Most of the time
    3. A good bit of the time
    4. Some of the time
    5. A little of the time
    6. Hardly any of the time
    7. None of the time

2. How often during the last 2 weeks have you delayed or canceled a social engagement because of your bowel problem?
    1. All of the time
    2. Most of the time
    3. A good bit of the time
    4. Some of the time
    5. A little of the time
    6. Hardly any of the time
    7. None of the time

3. As a result of your bowel problems, how much difficulty did you experience doing leisure or sports activities you would liked to have done during the past 2 weeks?
    1. A great deal of difficulty; activities made impossible
    2. A lot of difficulty
    3. A fair bit of difficulty
    4. Some difficulty
    5. A little difficulty
    6. Hardly any difficulty
    7. No difficulty; the bowel problem did not limit sports or leisure activities

4. How often during the past 2 weeks have you been troubled by pain in the abdomen?
    1. All of the time
    2. Most of the time
    3. A good bit of the time
    4. Some of the time
    5. A little of the time
    6. Hardly any of the time
    7. None of the time

5. How often during the past 2 weeks have you felt depressed or discouraged?
    1. All of the time
    2. Most of the time
    3. A good bit of the time
    4. Some of the time
    5. A little of the time
    6. Hardly any of the time
    7. None of the time

6. Overall, in the past 2 weeks, how much of a problem have you had with passing large amounts of gas?
    1. A major problem
    2. A big problem
    3. A significant problem
    4. Some problem
    5. A little trouble
    6. Hardly any trouble
    7. No trouble

7. Overall, in the past 2 weeks, how much of a problem have you had maintaining or getting to the weight you would like to be?
    1. A major problem
    2. A big problem

3. A significant problem
4. Some problem
5. A little trouble
6. Hardly any trouble
7. No trouble

8. How often during the past 2 weeks have you felt relaxed and free of tension?
1. All of the time
2. Most of the time
3. A good bit of the time
4. Some of the time
5. A little of the time
6. Hardly any of the time
7. None of the time

9. How much of the time during the past 2 weeks have you been troubled by a feeling of having to go to the bathroom even though your bowels were empty?
1. All of the time
2. Most of the time
3. A good bit of the time
4. Some of the time
5. A little of the time
6. Hardly any of the time
7. None of the time

10. How often during the past 2 weeks have you felt angry as a result of your bowel problem?
1. All of the time
2. Most of the time
3. A good bit of the time
4. Some of the time
5. A little of the time
6. Hardly any of the time
7. None of the time

# Shortened Premenstrual Assessment Form

Name: _____ Date: _____

For each of the symptoms below, circle the number that most closely describes the intensity of your premenstrual symptoms during your last cycle. These are symptoms that would occur during the premenstrual phase of your cycle. This phase begins about seven days prior to menstrual bleeding (or seven days before your period) and ends about the time bleeding starts. Rate each item on this list on a scale from 1 (not present or no change from usual) to 6 (extreme change, perhaps noticeable even to casual acquaintances).

| | | 1=No change | | | | | 6= Extreme change |
|---|---|---|---|---|---|---|---|
| 1. | Pain, tenderness, enlargement or swelling of breasts | 1 | 2 | 3 | 4 | 5 | 6 |
| 2. | Feeling unable to cope or overwhelmed by ordinary demands | 1 | 2 | 3 | 4 | 5 | 6 |
| 3. | Feeling under stress | 1 | 2 | 3 | 4 | 5 | 6 |
| 4. | Outburst of irritability or bad temper | 1 | 2 | 3 | 4 | 5 | 6 |
| 5. | Feeling sad or blue | 1 | 2 | 3 | 4 | 5 | 6 |
| 6. | Backaches, joint and muscle pain, or joint stiffness | 1 | 2 | 3 | 4 | 5 | 6 |
| 7. | Weight gain | 1 | 2 | 3 | 4 | 5 | 6 |
| 8. | Relatively steady abdominal heaviness, discomfort or pain | 1 | 2 | 3 | 4 | 5 | 6 |
| 9. | Edema, swelling, puffiness, or water retention | 1 | 2 | 3 | 4 | 5 | 6 |
| 10. | Feeling bloated | 1 | 2 | 3 | 4 | 5 | 6 |

Total Score:_____

## Adam Questionnaire (for men)

If you have concerns about “Andropause” and that your testosterone levels may be low, this set of ten simple questions is a good place to start.

Circle YES or NO to each of the following questions:

| | | |
|---|---|---|
| 1. Do you have a decrease in libido (sex drive)? | Yes | No |
| 2. Do you have a lack of energy? | Yes | No |
| 3. Do you have a decrease in strength and/or endurance? | Yes | No |
| 4. Have you lost height? | Yes | No |
| 5. Have you noticed a decreased "enjoyment of life?" | Yes | No |
| 6. Are you sad and/or grumpy? | Yes | No |
| 7. Are your erections less strong? | Yes | No |
| 8. Have you noticed a recent deterioration in your ability to play sports? | Yes | No |
| 9. Are you falling asleep after dinner? | Yes | No |
| 10. Has there been a recent deterioration in your work performance? | Yes | No |

If you answered YES to questions 1 or 7 or any 3 other questions, you may be experiencing androgen deficiency (low testosterone levels) and follow up testing may be useful.

Adapted from Morley, et al. Validation of a screening questionnaire for androgen deficiency in aging males. Metabolism. 2000;49(9):1239-1242

## Exposure History Form

**Part 1. Exposure Survey** **Name:** _____ **Date:** _____

*Please circle the appropriate answer.* **Birth date:** _____ **Sex (circle one):** Male Female

1. Are you currently exposed to any of the following?

| | | |
|---|---|---|
| metals | no | yes |
| dust or fibers | no | yes |
| chemicals | no | yes |
| fumes | no | yes |
| radiation | no | yes |
| biologic agents | no | yes |
| loud noise, vibration, extreme heat or cold | no | yes |

2. Have you been exposed to any of the above in the past? no yes

3. Do any household members have contact with metals, dust, fibers, chemicals, fumes, radiation, or biologic agents? no yes

If you answered *yes* to any of the items above, describe your exposure in detail—how you were exposed, to what you were exposed. If you need more space, please use a separate sheet of paper.

4. Do you know the names of the metals, dusts, fibers, chemicals, fumes, or radiation that you are/were exposed to? no yes

If *yes*, list them below

5. Do you get the material on your skin or clothing? no yes
6. Are your work clothes laundered at home? no yes
7. Do you shower at work? no yes
8. Can you smell the chemical or material you are working with? no yes
9. Do you use protective equipment such as gloves, masks, respirator, or hearing protectors? no yes

If *yes*, list the protective equipment used

10. Have you been advised to use protective equipment? no yes
11. Have you been instructed in the use of protective equipment? no yes

| | | | | | |
|---|---|---|---|---|---|
| 12. | Do you wash your hands with solvents? | no | yes | | |
| 13. | Do you smoke at the workplace? | no | yes | At home? | no yes |
| 14. | Are you exposed to secondhand tobacco smoke at the workplace? | no | yes | At home? | no yes |
| 15. | Do you eat at the workplace? | no | yes | | |
| 16. | Do you know of any co-workers experiencing similar or unusual symptoms? | no | yes | | |
| 17. | Are family members experiencing similar or unusual symptoms? | no | yes | | |
| 18. | Has there been a change in the health or behavior of family pets? | no | yes | | |
| 19. | Do your symptoms seem to be aggravated by a specific activity? | no | yes | | |
| 20. | Do your symptoms get either worse or better at work? | no | yes | | |
| | at home? | no | yes | | |
| | on weekends? | no | yes | | |
| | on vacation? | no | yes | | |

21. Has anything about your job changed in recent months (such as duties, procedures, overtime)? no yes

22. Do you use any traditional or alternative medicines? no yes

If you answered *yes* to any of the questions, please explain.

# Environmental Exposure History Form. Part II: Occupational Profile

**Part 2. Work History**
**A. Occupational Profile**

**Name:** _____
**Birth date:** _____ **Sex:** Male Female

The following questions refer to your current or most recent job:

Job title: _____ Describe this job: _____

Type of industry: _____ _____

Name of employer: _____ _____

Date job began: _____ _____

Are you still working in this job? yes no _____

If *no*, when did this job end? _____ _____

Fill in the table below listing all jobs you have worked including short-term, seasonal, part-time employment, and military service. Begin with your most recent job. Use additional paper if necessary.

| Dates of Employment | Job Title and Description of Work | Exposures* | Protective Equipment |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

*List the chemicals, dusts, fibers, fumes, radiation, biologic agents (i.e., molds or viruses) and physical agents (i.e., extreme heat, cold, vibration, or noise) that you were exposed to at this job.

Have you ever worked at a job or hobby in which you came in contact with any of the following by breathing, touching, or ingesting (swallowing)? If *yes*, please check the box beside the name.

| | | | |
|---|---|---|---|
| Acids | Chloroprene | Methylene chloride | Styrene |
| Alcohols (industrial) | Chromates | Nickel | Talc |
| Alkalis | Coal dust | PBBs | Toluene |
| Ammonia | Dichlorobenzene | PCBs | TDI or MDI |
| Arsenic | Ethylene dibromide | Perchloroethylene | Trichloroethylene |
| Asbestos | Ethylene dichloride | Pesticides | Trinitrotoluene |
| Benzene | Fiberglass | Phenol | Vinyl chloride |
| Beryllium | Halothane | Phosgene | Welding fumes |
| Cadmium | Isocyanates | Radiation | X-rays |
| Carbon Tetrachloride | Ketones | Rock dust | Other |
| Chlorinated naphthalenes | Lead | Silica powder | |
| Chloroform | Mercury | Solvents | |

**B. Occupational Exposure Inventory** *Please circle the appropriate answer.*

| | | | |
|---|---|---|---|
| 1. | Have you ever been off work for more than 1 day because of an illness related to work? | no | Yes |
| 2. | Have you ever been advised to change jobs or work assignments because of any health problems or injuries? | no | Yes |
| 3. | Has your work routine changed recently? | no | Yes |
| 4. | Is there poor ventilation in your workplace? | no | Yes |

**Part 3. Environmental History** *Please circle the appropriate answer.*

1. Do you live next to or near an industrial plant, commercial business, dump site, or nonresidential property? no yes

2. Which of the following do you have in your home?
*Please circle those that apply.*

| | | | | |
|---|---|---|---|---|
| Air conditioner | Air purifier | Central heating (gas or oil?) | Gas stove | Electric stove |
| Fireplace | Wood stove | Humidifier | | |

3. Have you recently acquired new furniture or carpet, refinished furniture, or remodeled your home? no Yes

4. Have you weatherized your home recently? no Yes

5. Are pesticides or herbicides (bug or weed killers; flea and tick sprays, collars, powders, or shampoos) used in your home or garden, or on pets? no Yes

6. Do you (or any household member) have a hobby or craft? no Yes

7. Do you work on your car? no Yes

8. Have you ever changed your residence because of a health problem? no Yes

9. Does your drinking water come from a private well, city water supply, or grocery store?

10. Approximately what year was your home built?_____

If you answered *yes* to any of the questions, please explain.

Comments:

Comments: