

NAME _____

DIET AND NUTRITION INFORMATION

Circle the appropriate number for each item: 1 = Daily, 2 = Weekly, 3 = Occasionally, 4 = Never.
Please use black ink.

1. How often do you eat or drink the following items:

Refined Sugar	1	2	3	4	Coffee	1	2	3	4
Pork	1	2	3	4	White Flour	1	2	3	4
Soda Pop	1	2	3	4	Alcohol	1	2	3	4
French Fries	1	2	3	4	Margarine	1	2	3	4

2. How many ounces of water do you drink per day? _____

3. How often are your bowel movements? _____

4. What vitamins and herbs are you currently taking? _____

5. List your typical breakfast: _____

Lunch _____

Evening meal _____

6. Do you use tobacco products? _____

7. Physician diagnosed illnesses? _____

8. Have you ever had radiation? _____ Chemotherapy? _____ If so, explain: _____

9. List your father's family ailments: _____

10. List your mother's family ailments: _____

Name _____

Please mark current issues with a "C" and past issues with a "P"

- | | | |
|---|--|--|
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Pain in Upper Chest |
| <input type="checkbox"/> Abscess | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Energy Low | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Panic Disorder |
| <input type="checkbox"/> Aneurysm | <input type="checkbox"/> Epstein | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Excess Weight | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Anxiety Attacks | <input type="checkbox"/> Fatigue (Excessive) | <input type="checkbox"/> Plaque on teeth |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Fibroid Cysts | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fungus | <input type="checkbox"/> Polyps |
| <input type="checkbox"/> Athlete's Foot | <input type="checkbox"/> Gallbladder Removed | <input type="checkbox"/> Prostatitis |
| <input type="checkbox"/> Belching | <input type="checkbox"/> Gastritis | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Bleeding (excessive) | <input type="checkbox"/> Gingivitis | <input type="checkbox"/> Rapid Heart Beat |
| <input type="checkbox"/> Blisters | <input type="checkbox"/> Glands Swollen | <input type="checkbox"/> Rectal itching |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Regurgitation |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Gout | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Blood Pressure (high) | <input type="checkbox"/> Headaches | <input type="checkbox"/> Ringworm |
| <input type="checkbox"/> Blood Pressure (low) | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Boils | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Breast Lumps | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Herpes | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Bruising | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Bruxism (grinding teeth) | <input type="checkbox"/> Hiccups | <input type="checkbox"/> Skin Cancer |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Hot Flashes | <input type="checkbox"/> Staph |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Sties |
| <input type="checkbox"/> Candidiasis | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Strep |
| <input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Tachycardia |
| <input type="checkbox"/> Cholesterol High | <input type="checkbox"/> Infections | <input type="checkbox"/> Teeth - loose |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Tendonitis |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Intestinal Gas | <input type="checkbox"/> Triglycerides High |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Itchy Ears | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cramps | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Under Weight |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Lung Pain | <input type="checkbox"/> Urinary Difficulty |
| <input type="checkbox"/> Deafness | <input type="checkbox"/> Lupus | <input type="checkbox"/> UTI |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Mastectomy | <input type="checkbox"/> Vaginal Discharge |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mastitis | <input type="checkbox"/> Vaginal Itch |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Vaginal Warts |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Menstrual Disorder | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Migraine | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Dizziness (Vertigo) | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Water Retention |
| <input type="checkbox"/> Dry Cough | <input type="checkbox"/> Ovarian Cysts/Pain | <input type="checkbox"/> Weight loss-excess |
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Pain in left chest | |

Please list your three main health concerns:
