BSI International
Integrative Natural Health

Yayasan Bali Sehat Indah International & PT Serba Alami Nusantara
Jalan Raya Uluwatu 1, GWK Park, Revayah Plaza, Suite A1 Ungasan, Bali, Indonesia
Tel. +62 (812) 3838 4040 Email: medical@bsi.international Web: www.bsi.international

HEALTH HISTORY QUESTIONNAIRE

ver. 13 Aug 2024

PART ONE : GETTING TO KNOW YOU

Patient's Full Name

Membership ☐ I am a BSI Member Patient ☐ I am not yet a Member Patient

Contact

Profession(s)

Working Status ☐ Working full or part ☐ Not working ☐ On vacation ☐ Retired ☐ Self-employed ☐ Other, please comment

Present Patient Location

Email

Please choose where you want to see the BSI Doctor…

☐ Canggu / Tibubeneng, Doctor Vincent, for all services
☐ Ubud / Sanggingan, for all services
☐ GWK / Jimbaran, Doctor Igo, for all services

Nationality

When would you like to book an appointment ?

Referred by Whom

Please tell us what services you seek at BSI. You may combine services as needed

☐ BSI Signature Holistic Health Reset & Detox
☐ Brain Fog & Memory Testing & Therapy
☐ Dengue Testing & Therapy
☐ Depression & Anxiety Nutraceutical Therapy
☐ Female Hormones Testing & Therapy
☐ Hypertension (High Blood Pressure) Testing & Therapy
☐ Insomnia (Sleep Disorders) Testing & Therapy
☐ NAD Longevity Therapy, NAD Addictions Therapy
☐ Male Hormones Testing & Therapy
☐ Parasites Testing & Therapy
☐ Smoking Cessation Program
☐ Super Bugs / Immunities Enhancement
☐ Youth Preservation

Please clarify in detail what you are requesting from BSI

Service Timing Parameters

☐ I am in Bali for 6 weeks or more, and can receive full services (recommended).
☐ I am in Bali for 3 weeks and can receive accelerated services, with remaining therapies taken home, with email counseling.
☐ I am in Bali 1-2 weeks, and can begin services, with remaining therapies taken home, with email counseling.
☐ I am in Bali for 3-4 business days, and can received initial testing and test results. Therapy will be taken when I return in less than 1 month.
☐ I am in Bali for 1-2 business days, and can receive initial testing only. I can receive results via email, with email counseling in less than 1 week (Extra charge). Therapy will be taken when I return in less than 1 month.
☐ I am in Bali for 1-2 business days, and can receive initial testing only. I can receive results via email, with on-line secure server video counseling for one hour, combined with subsequent email counseling. Video call must be taken in less than one week. (Extra charge). Therapy will be taken when I return in less than 1 month.

PART TWO : PATIENT VITAL INFORMATION

Are You Able to Care for Yourself, Able to Walk?

- ☐ YES, I am able to care for myself and walk
- ☐ NO, I am incapacitated.

Patient Gender

- ☐ Biological male
- ☐ Biological female
- ☐ Different options

Present Age in Years

Faith, Religion, or Practice

Date of Birth

PART THREE : PATIENT REQUEST FOR SERVICES

Please Fully Describe the Illness or Concerns

Present Weight

Present Height

Blood Type (if known)

Blood Thalassemia

- ☐ No, I do not have Thalassemia
- ☐ Yes, I have Thalassemia

Hemophilia

- ☐ No, I do not have Hemophilia
- ☐ Yes, I have Hemophilia

Describe Your Exercise Habits

- ☐ Type 0: Not much. Sedentary
- ☐ Type 1: Occasional short walking, relaxation
- ☐ Type 2: Yoga, Pilates, stretching, light to moderate swimming etc. Occasionally raise heart rate high
- ☐ Type 3: Occasional or frequent running, jumping, trampoline, jogging (lymphatic stimulation and impact exercise)
- ☐ Type 4: Weight lifting, muscle building, (endurance training)
- ☐ Type 5: Super Athletic, trains or works out nearly daily.

Stress Level

- ☐ 1 (No or very little stress, easy going, content)
- ☐ 2 (Normal stresses of managing a home or local environs, but happy)
- ☐ 3 (Normal stresses of challenging work or relationship, could use more rest)
- ☐ 4 (Moderate work stresses, challenging emotions, a little cranky but coping)
- ☐ 5 (Moderate or higher stresses from disease and / or home life / work life, need time off but can't)
- ☐ 6 (Very stressed and emotional, need distance, occasional snapping / yelling at others)
- ☐ 7 (Mild anger or sadness much of the time. Work hard to avoid conflict with others, may be taking related medications)
- ☐ 8 (Outraged most of the time, depressed, nothing makes sense, over-saturated with surroundings and society, yelling or striking at others)
- ☐ 9 (No hope, no patience, beyond ability to be calm or relaxed, unable to sleep)
- ☐ 10 (Totally unable to function in the world, restrained from public contact, fully anti-social)

Time I normally go to bed

Time I normally awaken

Nap

- ☐ I do not take naps
- ☐ I nap (how many times per week)
- ☐ I usually nap for how many minutes when I nap

Normal Sleep Habits

- ☐ I am told I snore at night
- ☐ I recover from jet lag with difficulty
- ☐ I have difficulty falling asleep
- ☐ I fall into a deep sleep
- ☐ My sleep hours are enough
- ☐ I feel vigorous after sleep
- ☐ I am satisfied with my sleep
- ☐ I have a clear head after sleep
- ☐ I wake up while sleeping
- ☐ I wake up easily because of noise
- ☐ I have difficulty getting back to sleep once
- ☐ I wake up in middle of the night
- ☐ I toss and turn
- ☐ I never go back to sleep after awakening during sleep
- ☐ Poor sleep gives me headaches
- ☐ Poor sleep makes me irritated
- ☐ Poor sleep makes me lose my appetite
- ☐ Poor sleep makes it hard for me to think
- ☐ Poor sleep makes it hard to concentrate
- ☐ Poor sleep makes me lose interest in work or others
- ☐ Poor sleep makes me forget things more easily
- ☐ Poor sleep makes me lose desire in all things
- ☐ Sleepiness interferes with my daily life
- ☐ I have difficulty getting out of bed
- ☐ I would like to sleep more after waking up
- ☐ I feel refreshed after sleep

Please comment here

PART FOUR : GENERAL HEALTH QUESTIONS

Usual Diet. Does the Patient Consume these Weekly or Daily?

- ☐ Wheat products (bread, pasta, noodles etc.)
- ☐ Sweet bakery items (donuts, cakes, cookies, etc.)
- ☐ Sweets, candies, chocolate, etc. each day
- ☐ Need to eat something sweet in or with most or all meals
- ☐ Common junk foods, chips, cakes, candies, etc
- ☐ Dairy products (milk, ice cream, cheese, yoghurt, etc.)
- ☐ Soy products (tofu, tempeh, soy sauce, soy flour, etc.)
- ☐ Processed, pre-packaged meats (canned meats of any kind, meat mixtures, bacon, lunch meats, sausage, etc.)
- ☐ Consume boxed, canned, bagged, pre-made foods from super markets (cereals, frozen meals, etc.)
- ☐ Low-grade fats, (oils of soy, canola, corn, highly processed oils, hydrolyzed shortening, etc.)
- ☐ Juices, cold-pressed juices, smoothies, shakes, etc.
- ☐ Powdered foods (spirulina, chlorella, whey, athletic blends, etc.)
- ☐ Soups, stews, etc.
- ☐ Coffee, tea, ginseng, chocolate (caffeine containing foods or beverages)
- ☐ Alcohol, beer, wine, mixed drinks. How often, and what type ?
- ☐ Clean fresh water. I drink how much each day?

Please comment here

- [ ] "White foods" (white rice, white noodles, white breads, white sugar, white milk, white salt, etc.)
- [ ] Raw foods (salads, nuts, sushi, etc.)
- [ ] Seed oils such as cotton seed, soy, canola, corn, palm, etc.
- [ ] Clear extra virgin coconut oil (EVCO) or extra virgin olive oil
- [ ] Wild or semi-wild foods, such avocado, mango, coconut, fresh ocean fish, berries, etc.
- [ ] Other not listed above. Please explain.

Foods and Beverages Consumed DAILY

Do You Eat in Restaurants / Cafes / Street Vendors, etc?

- [ ] Almost never
- [ ] 1-3 times per week
- [ ] 3-6 times per week
- [ ] 1 time each day
- [ ] 2 times each day
- [ ] 3 times each day

Please comment here

Nutritional Supplements – Total daily / weekly / monthly

- [ ] Vitamin A / total daily
- [ ] Vitamin B Complex or singular B vitamins / total daily
- [ ] Vitamin C tablets, pills, powders, etc. / total daily
- [ ] Vitamin D / total daily
- [ ] Vitamin E / total daily
- [ ] Minerals, combined or singular / total daily
- [ ] Green powders, spirulina, chlorella, etc. / total daily
- [ ] Body building powders / drinks, etc. / when and how much
- [ ] Probiotics. Please name type and how often.
- [ ] Herbal supplements / teas, powders, etc.
- [ ] BSI Therapure Nutraceuticals consumed presently or in the past
- [ ] Injectable supplements / when and totals
- [ ] Other nutritional items not listed here
- [ ] None of the above

Please comment here

General Health Questions

- [ ] Chronic or occasional pain? Please describe
- [ ] Recent fever
- [ ] New injuries. Please describe
- [ ] Old injuries. Please describe
- [ ] Cold chills or cold sweats
- [ ] High blood pressure
- [ ] Low blood pressure
- [ ] Legs and feet (swelling, stiff joints, etc.)
- [ ] Arteriosclerosis (blocked arteries)
- [ ] Never or none of the above

Please comment here

Brain and Head Area

- [ ] Balding, hair loss, blotchy hair, the patient's hair thinning or falling out prematurely
- [ ] Pressure headaches
- [ ] Throbbing headaches
- [ ] Back-of-the-head headaches
- [ ] Forehead headaches
- [ ] Headaches around or behind eyes
- [ ] Memory lapses
- [ ] Dizziness or fainting
- [ ] Diagnosed with a tumor or brain disease
- [ ] Brain or head injuries at any time in life
- [ ] Brain surgery
- [ ] Nervousness, shaking, lack of motor control, etc.
- [ ] Paralysis anywhere in the body
- [ ] Lack of feeling anywhere in the body
- [ ] Over-sensitivity anywhere in the body
- [ ] Stroke
- [ ] Scalp problems, dandruff, itching, flaking, etc.
- [ ] Tumors, growths, moles, warts, etc. on the scalp or head
- [ ] Other head surgeries, such as on the ear, nose, neck etc.
- [ ] Something not listed above
- [ ] None of the above

Please comment here

Oral and Dental

- [ ] I have very healthy teeth and gums
- [ ] I have missing teeth, how many
- [ ] I have chipped or partial teeth
- [ ] I have diseased or rotting teeth
- [ ] I have bleeding gums
- [ ] I have receding gums
- [ ] I have false teeth or dentures
- [ ] All or most original teeth been removed
- [ ] I have amalgam fillings, how many
- [ ] I have ceramic fillings, how many
- [ ] I have dental caps or crowns on original teeth
- [ ] I have new style, more recent root canals
- [ ] I have old style root canals
- [ ] I wear or have worn braces
- [ ] I have dentures or bridges
- [ ] I have ulcers or growths in my mouth or my tongue
- [ ] I have or have had oral herpes
- [ ] I have lost my sense of taste or smell
- [ ] I use commercial mouth wash
- [ ] I am told I have bad breath most of the time
- [ ] I have excessive amounts of mucous or saliva

Please comment here

Thyroid Disorders / Swelling

- [ ] Taking thyroid medication?
- [ ] Undergone thyroid surgery or removal?
- [ ] Thyroid area inflammed or in pain?
- [ ] Exposed to nuclear radation that may have affected the thyroid?
- [ ] Never or not sure

Please comment here

Sinus, Ears, Throat

- [ ] Recent or previous ear and/or sinus infections
- [ ] Any swelling or pain in the throat area
- [ ] Undergone surgeries in the throat or on the neck
- [ ] Recent or previous swollen or painful lymph glands in the neck or throat area
- [ ] Strained or dry voice
- [ ] Lumps or hard nodules anywhere in the mouth, sinus, gums
- [ ] Difficulties swallowing
- [ ] Sticky mucous in the throat area
- [ ] Something not listed above
- [ ] Never or note sure on all the above

Please comment here

Eyes

- [ ] Objects floating in vision ?
- [ ] Tunnel vision ?
- [ ] Poor night vision ?
- [ ] Wear corrective lenses ?
- [ ] Eye surgery (alignment, Lasix, repair, etc.) ?
- [ ] Full or partial blindness ?
- [ ] Something not listed above ?
- [ ] None of the above

Please comment here

Digestive System

- [ ] Difficulty when swallowing ?
- [ ] Specific digestive issues of the liver, gallbladder, pancreas, stomach, intestines, etc. Please explain.
- [ ] Do you have diabetes / hypoglycemia / sugar cravings ?
- [ ] Sometimes or often constipated ?
- [ ] Bloating, indigestion, vomiting, excessive gas, etc ?
- [ ] Occasional or frequent diarrhea ?
- [ ] Are the feces a strange color, grey, yellow, green, red, black ?
- [ ] Rectal bleeding, or blood in stool ?
- [ ] Hemorrhoids (piles)?
- [ ] Anal itching or irritation ?
- [ ] Cramping, abdominal pain ?
- [ ] Any other digestive condition not on the above list ?
- [ ] Never or none of the above

Please comment here

Skin and Body Surfaces

- [ ] Excessive sweating or body odors ? Please describe.
- [ ] Dry or scaly skin ?
- [ ] Growths, skin infections, skin irregularities of any kind on the body ? Where, please describe.
- [ ] Excessive bruising, discoloration or spots ? Please describe.

Please comment here

- [ ] Varicose veins / Thrombophlebitis ?
- [ ] Cosmetic skin peels / Glycolic Acid, etc.?
- [ ] Have you ever injected Botox or similar ?
- [ ] Fingernail or toenail changes ? Please describe
- [ ] Skin surgeries / transplants of any kind ? Result ?
- [ ] Treated for skin cancer or other growth ?
- [ ] Where on the body, and when
- [ ] Problems not listed above
- [ ] Never or none of these

Respiratory System

- [ ] Asthma / lung disorders ?
- [ ] Shortness of breath ?
- [ ] Chronic cough and/or chest pain ?
- [ ] Frequent infections ?
- [ ] Sinus and/or ear infections ? How are they treated ?
- [ ] Other problems not on this list ?
- [ ] Never or none of the above

Please comment here

Smoking

- [ ] Tobacco cigarettes, what brand(s), how often, from when to when please?
- [ ] Vaping ? What brand(s), how often, from when to when please ?
- [ ] Cigars, pipes, chewing tobacco, etc ?
- [ ] Substances other than tobacco ?
- [ ] Never or none of the above

Please comment here

Kidneys, Adrenal Glands, Bladder, Urinary Tract

- [ ] Urinary tract surgery? Cause and results ?
- [ ] Growths or eruptions on or around genitalia ?
- [ ] Swollen lymph or lumps in around the anus, perineum, genitals, and surrounding areas ?
- [ ] Do you experience any pain or discomfort regarding sex ?
- [ ] Take diuretics to facilitate urination ?
- [ ] Urinary tract infections ? Recent or frequent ?
- [ ] Burning or difficult urination ?
- [ ] Awakened at night to urinate ? How many times ?
- [ ] None of these or other response

Please comment here

Heart and Circulatory System

- [ ] Arrhythmia (irregular heartbeat) ?
- [ ] Tachycardia (abnormally fast heart rate) ?
- [ ] Bradycardia (abnormally slow heart rate) ?
- [ ] Ever suffered a heart attack ?
- [ ] Chest pains in or around the heart ?
- [ ] Heart or related surgeries or therapies ?
- [ ] Blood disorders ?
- [ ] Other answer not listed above
- [ ] Never, none of these

Please comment here

Male Considerations

- [ ] Prostate issues – surgery, pain, etc.
- [ ] Erectile problems ?
- [ ] Any strange discharge or irritation of the penis ?
- [ ] Testicle problems – swelling, discoloration, surgery, etc ?
- [ ] Sexually transmitted diseases (STDs) ? Now or in the past that may have affected your concerns here ?
- [ ] Taking hormones of any kind that affect reproduction ?
- [ ] Other condition not on this list. Please describe here
- [ ] Never or none of these

Please comment here

Female Considerations

- [ ] Surgery of the reproductive system ? Please answer when, reason, and result
- [ ] Pregnant now ?
- [ ] Using bith control of any kind ? What type, for how long ?
- [ ] Taking hormones of any kind that affect reproduction ?
- [ ] Currently menstruate on a consistant cycle ?
- [ ] Are menses very heavy or very light, of strange duration ? Please comment.
- [ ] Menopause ? How long ? Difficulties ?
- [ ] Sexually transmitted diseases (STDs) ? Now or in the past
- [ ] Vaginitis, pain, or or vaginal discharge ?
- [ ] Endometriosis ?
- [ ] Breast issues (swollen lymph, pain, etc.)
- [ ] Other condition not listed here
- [ ] Never or none of these

Please comment here

Projected beginning of cycle

Projected end of cycle

Female Considerations

Purpose of Testing: (when performing full testing, not just specific hormones) Please be sure to schedule hormone testing in sync with menstruation. Please choose your concerns below

- [ ] General hormonal function: Any time outside of menstruation
- [ ] PCOS: Anytime outside of menstruation
- [ ] Fertility / Ovarian function: Test on day 3 (but cannot do urine testing this day)
- [ ] Menopause / Peri-menopause : Day 3 (but cannot do urine testing this day)
- [ ] Heavy emotions: Around days 19-22
- [ ] Light or Heavy menses: Around days 19-22
- [ ] Specific concerns about Estrogen or Progesterone: Days 19-22
- [ ] Missing period: Any time

Please comment here

PART FIVE : PATIENT DISEASE AND CAUSES

Allergies

- [ ] Animals?
- [ ] Certain drugs?
- [ ] Diary products?
- [ ] Dust?
- [ ] Mold or mildew?
- [ ] Nuts or seeds?
- [ ] Other allergens not listed?
- [ ] Never or not sure

Please comment here

Autoimmune Disorders

- [ ] Alopecia areata.Sudden hair loss that starts with one or more circular bald patches that may overlap.
- [ ] Ankylosing spondylitis. An inflammatory arthritis affecting the spine and large joints.
- [ ] Celiac disease. An immune reaction to eating gluten, a protein found in wheat, barley and rye.
- [ ] Lupus. An inflammatory disease caused when the immune system attacks its own tissues.
- [ ] Multiple sclerosis. A disease in which the immune system eats away at the protective covering of nerves.
- [ ] Polymyalgia rheumatica. An inflammatory disorder causing muscle pain and stiffness around the shoulders and hips.
- [ ] Rheumatoid arthritis. A chronic inflammatory disorder affecting many joints, including those in the hands and feet.
- [ ] Sjögren's syndrome. An immune system disorder characterised by dry eyes and dry mouth.
- [ ] Temporal arteritis. An inflammation of blood vessels, called arteries, in and around the scalp.
- [ ] Type 1 diabetes. A chronic condition in which the pancreas produces little or no insulin.
- [ ] Vasculitis. An inflammation of the blood vessels that causes changes in the blood vessel walls.
- [ ] Other conditions not listed above.
- [ ] Never or not sure.

Please comment here

Cancers

- [ ] Do you now have cancer, or previously had cancer? Please comment
- [ ] Stage and type of cancer (if any, in detail please)
- [ ] Results of any previous medical tests. (Please provide most recent copies when we meet – please do not include here)
- [ ] Results of biopsy, if any
- [ ] Intravenous chemotherapy?
- [ ] Oral chemotherapy?
- [ ] Hormone therapy?
- [ ] Radiation therapy?
- [ ] Holistic or natural therapy for cancers and related diseases?
- [ ] Other not listed here. Please explain.
- [ ] Never, or not sure

Please comment here

Hepatitis or Liver Disease

- [ ] Yellowing of the eyes or skin?
- [ ] Hepatitis A (HAV) (Hepatitis A is spread primarily through food or water contaminated by stool from an infected person. Hepatitis A is a food-borne or waterborne illnesses.)
- [ ] Hepatitis B (HBV) (The hepatitis B virus is spread through blood, semen, or other body fluids.)
- [ ] Hepatitis C (HCV) (The hepatitis C virus is spread through contact with an infected person's blood — because of genital sores or cuts or menstruation. Also through injection drug use, unsafe injection practices, unsafe health care, and the transfusion of unscreened blood and blood products.)
- [ ] Hepatitis D. (HDV) (Hepatitis D infection only occurs in the presence of hepatitis B virus. HDV-HBV co-infection is considered the most severe form of chronic viral hepatitis.)
- [ ] Hepatitis E (HEV) (The hepatitis E virus is transmitted mainly through contaminated drinking water. It is usually a self-limiting infection and resolves within 4 to 6 weeks.)
- [ ] NON-viral Hepatitis. Please describe
- [ ] Never or none of the above

Please comment here

Herpes

- [ ] Herpes Simplex 1 (HSV-1) (oral cold sores in or around the mouth or lips. Associated with bipolar disorder, Alzheimer's disease and more)
- [ ] Herpes Simplex 2 (HSV-2) (gential / anal area breakouts. Associated with (Mollaret's meningitis)
- [ ] Herpes 3 (HHV-3 or VZV) (chickenpox, shingles, human herpes varicella-zoster)
- [ ] Herpes 4 (Epstein Barr HHV 4) (associated with mononucleosis, lymphomas, lupus, arthirtis, MS, Chronic Fatigue, etc.)
- [ ] Herpes 5 (cytomegalovirus HHV 5 or CMV) (associated with Infectious mononucleosis ('kissing disease'), retinities)
- [ ] Herpes 6 (HHV-6) (associated with Chronic Fatigue Syndrome, cognitive dysfunction, autonomic dysfunction, roseolovirus, lymphotroponic virus – infects approximatly 70% of humans. Symptoms consistent with hepatitis and encephalitis)
- [ ] Herpes 7 (HHV-7) (associated with pityriasis rosea. Also associated with drug-induced hypersensitivity syndrome, encephalopathy, hemiconvulsion-hemiplegia-epilepsy syndrome, hepatitis infection, postinfectious myeloradiculoneuropathy, pityriasis rosea, and the reactivation of HHV-4, leading to "mononucleosis-like illness"))
- [ ] Herpes 8 (HHV-8) (Associated with neoplasms. Diseases caused by HHV-8 infection include Kaposi Sarcoma, Multicentric Castleman Disease (MCD), Primary Effusion Lymphoma (PEL), which occur primarily in patients with HIV infection)

Please comment here

- [ ] ParvoVirus (B-19) (associated with slapped cheek syndrome, sero negative arthiritis, aplastic anemia, sickle cell disease, encephalitis, meningitis, stroke, peripheral neuropathy, and more)
- [ ] Not sure or other condition not listed above. Please explain
- [ ] Never or none of these

Toxic Exposures

Please comment here

- [ ] Exposed to chemicals or toxins related to machine work, solvents, fuels, industrial cleaners, etc?
- [ ] Insect or weed killers in the house or around where you are (how often, what brand?)
- [ ] Insect repellants sprayed or rubbed onto the body (how often, what brand?)
- [ ] Briefly describe any toxic chemical exposures at any time during the Patient's life
- [ ] Party favors in the past three years
- [ ] Other exposures not listed above. Please explain
- [ ] Never or none of the above

Radioactivity Exposures

Please comment here

- [ ] Radioactive exposures from frequent flying (how many flights per year ?)
- [ ] Radioactive exposures from CT scans, MRI, X-rays. How many times? Was 'contrast' injected into the body during the proceedure ?
- [ ] Use of cell phone next to the head (how many hours per day on average?)
- [ ] Live within 100 meters of a cellular or radio broadcast tower ? Please explain.
- [ ] Have lived or worked near a nuclear power plant or nuclear facility ?
- [ ] Have lived near or visited Chernobyl, Fukushima, Hanford or other contaminated area ?
- [ ] Have suffered from unexplained sudden hair loss or skin mottling, etc ?
- [ ] Any other source of radioactivity not listed above. Please explain
- [ ] Never or none of the above

PART SIX : MEDICATIONS PAST AND PRESENT

Common Medications the Patient has Taken during the Past 2 Years or Less

Please comment here

- [ ] Aspirin / Other pain killers
- [ ] Ibuprofen (Advil / Motrin)
- [ ] Panadol / Paracetamol / Tylenol / Benadryl / Acetaminophen
- [ ] Sudafed / Claritin / anti-histamine
- [ ] Diuretics (ease urination)
- [ ] Coumadin/ Heparin/ blood thinners (stroke prevention)
- [ ] Statins for cholesterol, (Lipitor, Crestor, Zocor)
- [ ] Prozac or similar
- [ ] Anti-fungal (on skin or orally)

- [ ] Estrogen / HGH / other hormones
- [ ] Other not listed above. Please describe. Thanks.
- [ ] None of these

All CURRENT medications, supplements, herbal medications, etc. you are taking

Vaccines or Inoculations – Did you have reactions ? If so, how and where? Did you experience the covid infection afterward ? Have you received these over the years?

Please comment here

- [ ] COVID 19 – FIRST SHOT – Please indicate BRAND NAME (Johnson & Johnson, AstraZeneca, Moderna, Pfizer, BioNtech, Sinovac, etc.) Please also indicate DATE and PLACE or CLINIC the shot was received (very important). Did you have reactions? Please explain.
- [ ] COVID 19 – SECOND SHOT – Did you have reactions ? Please explain.
- [ ] COVID 19 – FIRST BOOSTER SHOT – Did you have reactions ? Please explain.
- [ ] COVID 19 – SECOND BOOSTER SHOT – Did you have reactions ? Please explain.
- [ ] PCR SWAB – How many times have you taken the PCR / Swab ?
- [ ] Chickenpox (Varicella)
- [ ] Cholera
- [ ] Current flu vaccination every flu season
- [ ] Diphtheria-tetanus-pertussis (DTP) vaccine
- [ ] Haemophilus influenzae type b (Hib)
- [ ] Hepatitis A
- [ ] Hepatitis B
- [ ] HPV vaccine
- [ ] Japanese Encephalitis
- [ ] Malaria
- [ ] Measles-mumps-rubella (MMR) vaccine
- [ ] Meningococcalconugate vaccine
- [ ] Meningitis
- [ ] Pneumococcal (PCV)
- [ ] Polio vaccine
- [ ] Rabies
- [ ] Rotavirus (RV)
- [ ] Td or Tdap vaccine (tetanus, diphtheria, and pertussis) booster each 10 years.
- [ ] Typhoid and paratyphoid fever
- [ ] Varicella (chickenpox) vaccine
- [ ] Yellow Fever
- [ ] Zoster vaccine
- [ ] Other vaccination not listed above, please explain
- [ ] Not sure

Antibiotics in the Past 10 Years

Please comment here

- [ ] Amoxicillin. A penicillin antibiotic prescribed for tonsillitis, bronchitis, pneumonia, gonorrhea, and infections of the ear, nose, throat, skin, or urinary tract, and more.
- [ ] Amoxicillin / Clavulanate. A combination penicillin antibiotic that fights bacteria in the body.
- [ ] Azithromycin. Given for respiratory, skin, and ear infections, and sexually transmitted diseases.
- [ ] Cephalexin. Prescribed for upper respiratory infections, ear infections, skin infections, and urinary tract infections.
- [ ] Ciprofloxacin (fluoroquinolone). Prescribed for anthrax, plague, stomach disorders and more.
- [ ] Clindamycin. A wide-spectrum antibiotic that fights bacteria in the body.
- [ ] Doxycycline. For urinary tract infections, intestinal infections, eye infections, gonorrhea, chlamydia, periodontitis (gum disease), and others.
- [ ] Levofloxacin (fluoroquinolone). For skin, sinuses, kidneys, bladder, prostate, bronchitis, pneumonia, anthrax.
- [ ] Metronidazole (Clindamycin hydrochloride). A strong wide spectrum antibiotic that fights bacteria in the body.
- [ ] Sulfamethoxazole / Trimethoprim. Used to treat or prevent wide spectrum of bacterial infections.
- [ ] An antibiotic not on this list.
- [ ] Exposure from foods such as chicken, eggs, fish, meat, etc.
- [ ] Never have taken antibiotics.

PART SEVEN : MEDICATIONS PAST AND PRESENT

Happiness and Well Being

Please comment here

- [ ] I am generally happy and content…
- [ ] My strengths are…
- [ ] My weaknesses are…
- [ ] I suffer / have suffered from depression…
- [ ] I suffer / have suffered from anxiety…
- [ ] I have taken / take medications for depression or anxiety...
- [ ] I am easily angered, triggered by…
- [ ] I practice / have practiced a form of mind centering, such as meditation or quiet time…
- [ ] Other answer not listed above

Therapies Received in the Past 2 Years or Now Receiving

Please comment here

- [ ] Acupuncture
- [ ] Aromatherapy
- [ ] Chelation therapy
- [ ] Colonic therapy
- [ ] Detoxing
- [ ] Cannabis
- [ ] Chemotherapy
- [ ] Herbal medicine
- [ ] Homeopathy

- [ ] Naturopathy
- [ ] Oxygen therapy
- [ ] Prolo Therapy
- [ ] Radiation Therapy
- [ ] Reiki
- [ ] Vitamin C infusions (dosage, how often, any side effects ?)
- [ ] Other therapy not on this list
- [ ] Never or none of the above

Surgeries and Operations

- [ ] Appendix removed — **Please comment here**
- [ ] Tonsils removed
- [ ] Digestive surgeries
- [ ] Elective surgeries. Please explain
- [ ] Emergency surgeries
- [ ] Eye operations
- [ ] Heart
- [ ] Skin operations, including growths or cancers, etc.
- [ ] Other surgeries not listed above, please explain here
- [ ] None of the above

Anti-Fungal Medicines

- [ ] Oral anti-fungal medicines? — **Please comment here**
- [ ] Topical anti-fungals?
- [ ] Not sure or other medicine, please explain
- [ ] Never or none of the above

Parasites

- [ ] Treated for digestive parasites? If so when and how. Did the treatment work? — **Please comment here**
- [ ] Treated for skin or hair parasites?
- [ ] Frequent bloating or gas?
- [ ] Anal bleeding or itching?
- [ ] Strings or mucous in the stools?
- [ ] Do you live with dogs or cats?
- [ ] Other parasite problems not listed here. Please explain
- [ ] Never or none of these. Please explain

Anything Else of Relevance

Note :
Please fill this offline form, then Save it
Send this form via email to : **survey@bsi.international**
- or -
Print and bring with you to your first meeting.
(Please note this will add 30 minutes to your first visit).