BSI

Integrative Natural Health

HEALTH HISTORY QUESTIONNAIRE

We're on your side, here to help

ver. 30 Dec 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, Doctor Steven, for all services
☐ GWK / Jimbaran, Doctor Igo, for all services
☐ GWK / Jimbaran, Doctor Mona, for all services

Nationality

When would you like to book an appointment ?

Referred by Whom

Please tell us what services you seek at BSI ...

☐ BSI Signature Holistic Health Reset & Detox, Testing & Diagnosis with Natural Therapies - Rp. 4.300.000
☐ Deep Dive Parasites & Diseases Testing & Remedies Service - Rp. 5.500.000
☐ Female Hormones Testing & Therapy, Testing & Diagnosis with Natural Therapies - Rp. 7.700.000
☐ Male Hormones Testing & Therapy, Testing & Diagnosis with Natural Therapies - Rp. 7.700.000

* not including prescribed medicines & therapies

The following services can be included without additional doctor charges (however medicines or testing are charged at normal rates), if requested here in advance. Therapies and medicines are quoted after testing is completed.

Please clarify in detail what you are requesting from BSI

☐ Brain Fog & Memory Testing & Therapy
☐ Depression & Anxiety Nutraceutical Therapy
☐ Hypertension (High Blood Pressure) Testing & Therapy
☐ Insomnia (Sleep Disorders) Testing & Therapy
☐ NAD A+ Longevity Therapy, NAD A+ Addictions Therapy
☐ Smoking Cessation Program
☐ Not requested

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?

If possible, please tell us the names of those you most frequent, and your review of them. We publish a list of eateries suitable for our patients.

- [ ] Almost never — **Please comment here**
- [ ] 1-3 times per week
- [ ] 3-6 times per week
- [ ] 1 time each day
- [ ] 2 times each day
- [ ] 3 times each day

Nutritional Supplements – Total daily / weekly / monthly

- [ ] Vitamin A / total daily — **Please comment here**
- [ ] 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 / medicines / vitamins when & totals
- [ ] Other nutritional items not listed here
- [ ] None of the above

General Health Questions

- [ ] Chronic or occasional pain? Please describe — **Please comment here**
- [ ] 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

Brain and Head Area

Please comment here

- [ ] 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

Oral and Dental

Please comment here

- [ ] 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

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: Testing can be taken any time outside of menstruation
- ☐ PCOS: Testing anytime outside of menstruation
- ☐ Fertility / Ovarian function: Testing on day 3 (but cannot do urine testing this day)
- ☐ Menopause / Peri-menopause : Testing on day 3 (but cannot do urine testing this day)
- ☐ Heavy emotions: Testing around days 19-22
- ☐ Light or Heavy menses: Testing around days 19-22
- ☐ Specific concerns about Estrogen or Progesterone: Testing days 19-22
- ☐ Missing period: Testing 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
- [ ] 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

Please comment here

Anti-Fungal Medicines

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

Please comment here

Parasites

- [ ] Treated for digestive parasites? If so when and how. Did the treatment work?
- [ ] 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

Please comment here

Anything Else of Relevance

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