

# Nutritional Assessment Questionnaire 1.5

Name: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Birth Date: \_\_\_\_\_

Gender: \_\_\_\_\_

Please list your five major health concerns in order of importance:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Notes:

**PART I Read the following questions and circle the number that applies:**

**KEY: 0 = Do not consume or use                    2 = Consume or use weekly**  
**1 = Consume or use 2 to 3 times monthly      3 = Consume or use daily**

**DIET**

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|---|----------------------------------|---|
| 1. 0 1 2 3 Alcohol                        | 7. 0 1 2 3 Cigars/pipes          | 14. 0 1 Radiation exposure (0=no, 1=yes)  |
| 2. 0 1 2 3 Artificial sweeteners          | 8. 0 1 2 3 Caffeinated beverages | 15. 0 1 2 3 Refined flour/baked goods     |
| 3. 0 1 2 3 Candy, desserts, refined sugar | 9. 0 1 2 3 Fast foods            | 16. 0 1 2 3 Vitamins and minerals         |
| 4. 0 1 2 3 Carbonated beverages           | 10. 0 1 2 3 Fried foods          | 17. 0 1 2 3 Water, distilled              |
| 5. 0 1 2 3 Chewing tobacco                | 11. 0 1 2 3 Luncheon meats       | 18. 0 1 2 3 Water, tap                    |
| 6. 0 1 2 3 Cigarettes                     | 12. 0 1 2 3 Margarine            | 19. 0 1 2 3 Water, well                   |
|   | 13. 0 1 2 3 Milk products        | 20. 0 1 2 3 Diet often for weight control |

**LIFESTYLE**

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21. 0 1 2 3 Exercise per week (0 = 2 or more times a week, 1 = 1 time a week, 2 = 1 or 2 times a month, 3 = never, less than once a month)
22. 0 1 2 3 Changed jobs (0 = over 12 months ago, 1 = within last 12 months, 2 = within last 6 months, 3 = within last 2 months)
23. 0 1 2 3 Divorced (0 = never, over 2 years ago, 1 = within last 2 years, 2 = within last year, 3 = within last 6 months)
24. 0 1 2 3 Work over 60 hours/week (0 = never, 1 = occasionally, 2 = usually, 3 = always)

**MEDICATIONS Indicate any medications you're currently taking or have taken in the last month (0=no, 1=yes):**

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|--|---|
| 25. 0 1 Antacids                                   | 39. 0 1 Diuretics   |
| 26. 0 1 Antianxiety medications                    | 40. 0 1 Estrogen or progesterone (pharmaceutical, prescription) |
| 27. 0 1 Antibiotics                                | 41. 0 1 Estrogen or progesterone (natural)                      |
| 28. 0 1 Anticonvulsants                            | 42. 0 1 Heart medications                                       |
| 29. 0 1 Antidepressants                            | 43. 0 1 High blood pressure medications                         |
| 30. 0 1 Antifungals                                | 44. 0 1 Laxatives   |
| 31. 0 1 Aspirin/Ibuprofen                          | 45. 0 1 Recreational drugs                                      |
| 32. 0 1 Asthma inhalers                            | 46. 0 1 Relaxants/Sleeping pills                                |
| 33. 0 1 Beta blockers                              | 47. 0 1 Testosterone (natural or prescription)                  |
| 34. 0 1 Birth control pills/implant contraceptives | 48. 0 1 Thyroid medication                                      |
| 35. 0 1 Chemotherapy                               | 49. 0 1 Acetaminophen (Tylenol)                                 |
| 36. 0 1 Cholesterol lowering medications           | 50. 0 1 Ulcer medications                                       |
| 37. 0 1 Cortisone/steroids                         | 51. 0 1 Sildenafil citrate (Viagra)                             |
| 38. 0 1 Diabetic medications/insulin               |   |

**PART II (See key at bottom of page)****Section 1**

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|---|--|
| 52. 0 1 2 3 Belching or gas within one hour after eating        | 61. 0 1 2 3 Feel like skipping breakfast           |
| 53. 0 1 2 3 Heartburn or acid reflux                            | 62. 0 1 2 3 Feel better if you don't eat           |
| 54. 0 1 2 3 Bloating within one hour after eating               | 63. 0 1 2 3 Sleepy after meals                     |
| 55. 0 1 Vegan diet (no dairy, meat, fish or eggs) (0=no, 1=yes) | 64. 0 1 2 3 Fingernails chip, peel or break easily |
| 56. 0 1 2 3 Bad breath (halitosis)                              | 65. 0 1 2 3 Anemia unresponsive to iron            |
| 57. 0 1 2 3 Loss of taste for meat                              | 66. 0 1 2 3 Stomach pains or cramps                |
| 58. 0 1 2 3 Sweat has a strong odor                             | 67. 0 1 2 3 Diarrhea, chronic                      |
| 59. 0 1 2 3 Stomach upset by taking vitamins                    | 68. 0 1 2 3 Diarrhea shortly after meals           |
| 60. 0 1 2 3 Sense of excess fullness after meals                | 69. 0 1 2 3 Black or tarry colored stools          |
|   | 70. 0 1 2 3 Undigested food in stool               |

KEY: 0=No, symptom does not occur                    2=Moderate symptom, occurs occasionally (weekly)  
 1=Yes, minor or mild symptom, rarely occurs (monthly)                    3=Severe symptom, occurs frequently (daily)

**Section 2**

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|------------|---------|--|------------|---------|--|
| <b>71.</b> | 0 1 2 3 | Pain between shoulder blades   | <b>85.</b> | 0 1     | Easily hung over if you were to drink wine (0=no, 1=yes)       |
| <b>72.</b> | 0 1 2 3 | Stomach upset by greasy foods  | <b>86.</b> | 0 1 2 3 | Alcohol per week (0=<3, 1=<7, 2=<14, 3=>14)                    |
| <b>73.</b> | 0 1 2 3 | Greasy or shiny stools   | <b>87.</b> | 0 1     | Recovering alcoholic (0=no, 1=yes)                             |
| <b>74.</b> | 0 1 2 3 | Nausea   | <b>88.</b> | 0 1     | History of drug or alcohol abuse (0=no, 1=yes)                 |
| <b>75.</b> | 0 1 2 3 | Sea, car, airplane or motion sickness  | <b>89.</b> | 0 1     | History of hepatitis (0=no, 1=yes)                             |
| <b>76.</b> | 0 1     | History of morning sickness (0 = no, 1 = yes)  | <b>90.</b> | 0 1     | Long term use of prescription/recreational drugs (0=no, 1=yes) |
| <b>77.</b> | 0 1 2 3 | Light or clay colored stools   | <b>91.</b> | 0 1 2 3 | Sensitive to chemicals (perfume, cleaning agents, etc.)        |
| <b>78.</b> | 0 1 2 3 | Dry skin, itchy feet or skin peels on feet   | <b>92.</b> | 0 1 2 3 | Sensitive to tobacco smoke                                     |
| <b>79.</b> | 0 1 2 3 | Headache over eyes   | <b>93.</b> | 0 1 2 3 | Exposure to diesel fumes                                       |
| <b>80.</b> | 0 1 2 3 | Gallbladder attacks (0=never, 1=years ago, 2=within last year, 3=within past 3 months) | <b>94.</b> | 0 1 2 3 | Pain under right side of rib cage                              |
| <b>81.</b> | 0 1     | Gallbladder removed (0=no, 1=yes)  | <b>95.</b> | 0 1 2 3 | Hemorrhoids or varicose veins                                  |
| <b>82.</b> | 0 1 2 3 | Bitter taste in mouth, especially after meals  | <b>96.</b> | 0 1 2 3 | Nutrasweet (aspartame) consumption                             |
| <b>83.</b> | 0 1     | Become sick if you were to drink wine (0=no, 1=yes)                                    | <b>97.</b> | 0 1 2 3 | Sensitive to Nutrasweet (aspartame)                            |
| <b>84.</b> | 0 1     | Easily intoxicated if you were to drink wine (0=no, 1=yes)                             | <b>98.</b> | 0 1 2 3 | Chronic fatigue or Fibromyalgia                                |

**Section 3**

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|-------------|---------|--|-------------|---------|--|
| <b>99.</b>  | 0 1 2 3 | Food allergies   | <b>108.</b> | 0 1 2 3 | Crohn's disease (0 =no, 1=yes in the past, 2=current mild condition, 3=severe) |
| <b>100.</b> | 0 1 2 3 | Abdominal bloating 1 to 2 hours after eating           | <b>109.</b> | 0 1 2 3 | Wheat or grain sensitivity   |
| <b>101.</b> | 0 1     | Specific foods make you tired or bloated (0=no, 1=yes) | <b>110.</b> | 0 1 2 3 | Dairy sensitivity  |
| <b>102.</b> | 0 1 2 3 | Pulse speeds after eating                              | <b>111.</b> | 0 1     | Are there foods you could not give up (0=no, 1=yes)                            |
| <b>103.</b> | 0 1 2 3 | Airborne allergies                                     | <b>112.</b> | 0 1 2 3 | Asthma, sinus infections, stuffy nose  |
| <b>104.</b> | 0 1 2 3 | Experience hives                                       | <b>113.</b> | 0 1 2 3 | Bizarre vivid dreams, nightmares   |
| <b>105.</b> | 0 1 2 3 | Sinus congestion, "stuffy head"                        | <b>114.</b> | 0 1 2 3 | Use over-the-counter pain medications  |
| <b>106.</b> | 0 1 2 3 | Crave bread or noodles                                 | <b>115.</b> | 0 1 2 3 | Feel spacey or unreal  |
| <b>107.</b> | 0 1 2 3 | Alternating constipation and diarrhea                  |             |         |  |

**Section 4**

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|-------------|---------|---|-------------|---------|--|
| <b>116.</b> | 0 1 2 3 | Anus itches   | <b>126.</b> | 0 1 2 3 | Stools have corners or edges, are flat or ribbon shaped        |
| <b>117.</b> | 0 1 2 3 | Coated tongue   | <b>127.</b> | 0 1 2 3 | Stools are not well formed (loose)                             |
| <b>118.</b> | 0 1 2 3 | Feel worse in moldy or musty place  | <b>128.</b> | 0 1 2 3 | Irritable bowel or mucus colitis                               |
| <b>119.</b> | 0 1 2 3 | Taken antibiotic for a total accumulated time of (0=never, 1= <1 month, 2= <3 months, 3= >3 months) | <b>129.</b> | 0 1 2 3 | Blood in stool   |
| <b>120.</b> | 0 1 2 3 | Fungus or yeast infections  | <b>130.</b> | 0 1 2 3 | Mucus in stool   |
| <b>121.</b> | 0 1 2 3 | Ring worm, "jock itch", "athletes foot", nail fungus  | <b>131.</b> | 0 1 2 3 | Excessive foul smelling lower bowel gas                        |
| <b>122.</b> | 0 1 2 3 | Yeast symptoms increase with sugar, starch or alcohol   | <b>132.</b> | 0 1 2 3 | Bad breath or strong body odors                                |
| <b>123.</b> | 0 1 2 3 | Stools hard or difficult to pass  | <b>133.</b> | 0 1 2 3 | Painful to press along outer sides of thighs (Iliotibial Band) |
| <b>124.</b> | 0 1     | History of parasites (0=no, 1=yes)  | <b>134.</b> | 0 1 2 3 | Cramping in lower abdominal region                             |
| <b>125.</b> | 0 1 2 3 | Less than one bowel movement per day  | <b>135.</b> | 0 1 2 3 | Dark circles under eyes  |

**Section 5**

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|-------------|---------|--|-------------|---------|-------------------------------------|
| <b>136.</b> | 0 1     | History of carpal tunnel syndrome (0=no, 1=yes)                                  | <b>150.</b> | 0 1     | History of bone spurs (0=no, 1=yes) |
| <b>137.</b> | 0 1     | History of lower right abdominal pains or ileocecal valve problems (0=no, 1=yes) | <b>151.</b> | 0 1 2 3 | Morning stiffness                   |
| <b>138.</b> | 0 1     | History of stress fracture (0=no, 1=yes)   | <b>152.</b> | 0 1 2 3 | Nausea with vomiting                |
| <b>139.</b> | 0 1 2 3 | Bone loss (reduced density on bone scan)   | <b>153.</b> | 0 1 2 3 | Crave chocolate                     |
| <b>140.</b> | 0 1     | Are you shorter than you used to be? (0=no, 1=yes)                               | <b>154.</b> | 0 1 2 3 | Feet have a strong odor             |
| <b>141.</b> | 0 1 2 3 | Calf, foot or toe cramps at rest   | <b>155.</b> | 0 1 2 3 | History of anemia                   |
| <b>142.</b> | 0 1 2 3 | Cold sores, fever blisters or herpes lesions                                     | <b>156.</b> | 0 1 2 3 | Whites of eyes (sclera) blue tinted |
| <b>143.</b> | 0 1 2 3 | Frequent fevers  | <b>157.</b> | 0 1 2 3 | Hoarseness                          |
| <b>144.</b> | 0 1 2 3 | Frequent skin rashes and/or hives  | <b>158.</b> | 0 1 2 3 | Difficulty swallowing               |
| <b>145.</b> | 0 1     | Herniated disc (0=no, 1=yes)   | <b>159.</b> | 0 1 2 3 | Lump in throat                      |
| <b>146.</b> | 0 1 2 3 | Excessively flexible joints, "double jointed"                                    | <b>160.</b> | 0 1 2 3 | Dry mouth, eyes and/or nose         |
| <b>147.</b> | 0 1 2 3 | Joints pop or click  | <b>161.</b> | 0 1 2 3 | Gag easily                          |
| <b>148.</b> | 0 1 2 3 | Pain or swelling in joints   | <b>162.</b> | 0 1 2 3 | White spots on fingernails          |
| <b>149.</b> | 0 1 2 3 | Bursitis or tendonitis   | <b>163.</b> | 0 1 2 3 | Cuts heal slowly and/or scar easily |
|             |         |  | <b>164.</b> | 0 1 2 3 | Decreased sense of taste or smell   |

KEY: 0=No, symptom does not occur	2=Moderate symptom, occurs occasionally (weekly)
1=Yes, minor or mild symptom, rarely occurs (monthly)	3=Severe symptom, occurs frequently (daily)

**Section 6**

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|------|---------|--|------|---------|--|
| 165. | 0 1     | Experience pain relief with aspirin (0=no, 1=yes)                                | 169. | 0 1 2 3 | Headaches when out in the hot sun      |
| 166. | 0 1 2 3 | Crave fatty or greasy foods  | 170. | 0 1 2 3 | Sunburn easily or suffer sun poisoning |
| 167. | 0 1 2 3 | Low- or reduced-fat diet (0=never, 1=years ago, 2=within past year, 3=currently) | 171. | 0 1 2 3 | Muscles easily fatigued                |
| 168. | 0 1 2 3 | Tension headaches at base of skull   | 172. | 0 1 2 3 | Dry flaky skin or dandruff             |

**Section 7**

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|------|---------|--|------|---------|--|
| 173. | 0 1 2 3 | Awaken a few hours after falling asleep, hard to get back to sleep | 180. | 0 1 2 3 | Headache if meals are skipped or delayed                                 |
| 174. | 0 1 2 3 | Crave sweets   | 181. | 0 1 2 3 | Irritable before meals   |
| 175. | 0 1 2 3 | Binge or uncontrolled eating                                       | 182. | 0 1 2 3 | Shaky if meals delayed   |
| 176. | 0 1 2 3 | Excessive appetite   | 183. | 0 1 2 3 | Family members with diabetes (0=none, 1=1 or 2, 2=3 or 4, 3=more than 4) |
| 177. | 0 1 2 3 | Crave coffee or sugar in the afternoon                             | 184. | 0 1 2 3 | Frequent thirst  |
| 178. | 0 1 2 3 | Sleepy in afternoon  | 185. | 0 1 2 3 | Frequent urination   |
| 179. | 0 1 2 3 | Fatigue that is relieved by eating                                 |      |         |  |

**Section 8**

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|------|---------|---|------|---------|--|
| 186. | 0 1 2 3 | Muscles become easily fatigued                  | 200. | 0 1 2 3 | Can hear heart beat on pillow at night       |
| 187. | 0 1 2 3 | Feel exhausted or sore after moderate exercise  | 201. | 0 1 2 3 | Whole body or limb jerk as falling asleep    |
| 188. | 0 1 2 3 | Vulnerable to insect bites                      | 202. | 0 1 2 3 | Night sweats                                 |
| 189. | 0 1 2 3 | Loss of muscle tone, heaviness in arms/legs     | 203. | 0 1 2 3 | Restless leg syndrome                        |
| 190. | 0 1 2 3 | Enlarged heart or congestive heart failure      | 204. | 0 1 2 3 | Cracks at corner of mouth (Cheilosis)        |
| 191. | 0 1 2 3 | Pulse below 65 per minute (0=no, 1=yes)         | 205. | 0 1 2 3 | Fragile skin, easily chaffed, as in shaving  |
| 192. | 0 1 2 3 | Ringing in the ears (Tinnitus)                  | 206. | 0 1 2 3 | Polyps or warts                              |
| 193. | 0 1 2 3 | Numbness, tingling or itching in hands and feet | 207. | 0 1 2 3 | MSG sensitivity                              |
| 194. | 0 1 2 3 | Depressed                                       | 208. | 0 1 2 3 | Wake up without remembering dreams           |
| 195. | 0 1 2 3 | Fear of impending doom                          | 209. | 0 1 2 3 | Small bumps on back of arms                  |
| 196. | 0 1 2 3 | Worrier, apprehensive, anxious                  | 210. | 0 1 2 3 | Strong light at night irritates eyes         |
| 197. | 0 1 2 3 | Nervous or agitated                             | 211. | 0 1 2 3 | Nose bleeds and/or tend to bruise easily     |
| 198. | 0 1 2 3 | Feelings of insecurity                          | 212. | 0 1 2 3 | Bleeding gums especially when brushing teeth |
| 199. | 0 1 2 3 | Heart races                                     |      |         |  |

**Section 9**

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|------|---------|--|------|---------|--|
| 213. | 0 1 2 3 | Tend to be a "night person"                    | 226. | 0 1 2 3 | Arthritic tendencies                         |
| 214. | 0 1 2 3 | Difficulty falling asleep                      | 227. | 0 1 2 3 | Crave salty foods                            |
| 215. | 0 1 2 3 | Slow starter in the morning                    | 228. | 0 1 2 3 | Salt foods before tasting                    |
| 216. | 0 1 2 3 | Tend to be keyed up, trouble calming down      | 229. | 0 1 2 3 | Perspire easily                              |
| 217. | 0 1 2 3 | Blood pressure above 120/80                    | 230. | 0 1 2 3 | Chronic fatigue, or get drowsy often         |
| 218. | 0 1 2 3 | Headache after exercising                      | 231. | 0 1 2 3 | Afternoon yawning                            |
| 219. | 0 1 2 3 | Feeling wired or jittery after drinking coffee | 232. | 0 1 2 3 | Afternoon headache                           |
| 220. | 0 1 2 3 | Clench or grind teeth                          | 233. | 0 1 2 3 | Asthma, wheezing or difficulty breathing     |
| 221. | 0 1 2 3 | Calm on the outside, troubled on the inside    | 234. | 0 1 2 3 | Pain on the medial or inner side of the knee |
| 222. | 0 1 2 3 | Chronic low back pain, worse with fatigue      | 235. | 0 1 2 3 | Tendency to sprain ankles or "shin splints"  |
| 223. | 0 1 2 3 | Become dizzy when standing up suddenly         | 236. | 0 1 2 3 | Tendency to need sunglasses                  |
| 224. | 0 1 2 3 | Difficulty maintaining manipulative correction | 237. | 0 1 2 3 | Allergies and/or hives                       |
| 225. | 0 1 2 3 | Pain after manipulative correction             | 238. | 0 1 2 3 | Weakness, dizziness                          |

**Section 10**

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- |      |         |   |      |         |   |
|------|---------|---|------|---------|---|
| 239. | 0 1     | Height over 6' 6" (0=no, 1=yes)                           | 245. | 0 1     | Height under 4' 10" (0=no, 1=yes)                       |
| 240. | 0 1     | Early sexual development (before age 10) (0=no, 1=yes)    | 246. | 0 1 2 3 | Decreased libido  |
| 241. | 0 1 2 3 | Increased libido  | 247. | 0 1 2 3 | Excessive thirst  |
| 242. | 0 1 2 3 | Splitting type headache                                   | 248. | 0 1 2 3 | Weight gain around hips or waist                        |
| 243. | 0 1 2 3 | Memory failing  | 249. | 0 1 2 3 | Menstrual disorders                                     |
| 244. | 0 1     | Tolerate sugar, feel fine when eating sugar (0=no, 1=yes) | 250. | 0 1     | Delayed sexual development (after age 13) (0=no, 1=yes) |
|      |         |   | 251. | 0 1 2 3 | Tendency to ulcers or colitis                           |

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**Section 11** 48

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|--|--|
| 252. 0 1 2 3 Sensitive/allergic to iodine                        | 260. 0 1 2 3 Mentally sluggish, reduced initiative                     |
| 253. 0 1 2 3 Difficulty gaining weight, even with large appetite | 261. 0 1 2 3 Easily fatigued, sleepy during the day                    |
| 254. 0 1 2 3 Nervous, emotional, can't work under pressure       | 262. 0 1 2 3 Sensitive to cold, poor circulation (cold hands and feet) |
| 255. 0 1 2 3 Inward trembling                                    | 263. 0 1 2 3 Constipation, chronic                                     |
| 256. 0 1 2 3 Flush easily  | 264. 0 1 2 3 Excessive hair loss and/or coarse hair                    |
| 257. 0 1 2 3 Fast pulse at rest                                  | 265. 0 1 2 3 Morning headaches, wear off during the day                |
| 258. 0 1 2 3 Intolerance to high temperatures                    | 266. 0 1 2 3 Loss of lateral 1/3 of eyebrow                            |
| 259. 0 1 2 3 Difficulty losing weight                            | 267. 0 1 2 3 Seasonal sadness  |

**Section 12 – Men Only** 27

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|---|--|
| 268. 0 1 2 3 Prostate problems                        | 272. 0 1 2 3 Waking to urinate at night              |
| 269. 0 1 2 3 Difficulty with urination, dribbling     | 273. 0 1 2 3 Interruption of stream during urination |
| 270. 0 1 2 3 Difficult to start and stop urine stream | 274. 0 1 2 3 Pain on inside of legs or heels         |
| 271. 0 1 2 3 Pain or burning with urination           | 275. 0 1 2 3 Feeling of incomplete bowel evacuation  |
|   | 276. 0 1 2 3 Decreased sexual function               |

**Section 13 – Women Only** 60

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|--|---|
| 277. 0 1 2 3 Depression during periods                 | 287. 0 1 2 3 Breast fibroids, benign masses               |
| 278. 0 1 2 3 Mood swings associated with periods (PMS) | 288. 0 1 2 3 Painful intercourse (dysparenia)             |
| 279. 0 1 2 3 Crave chocolate around periods            | 289. 0 1 2 3 Vaginal discharge                            |
| 280. 0 1 2 3 Breast tenderness associated with cycle   | 290. 0 1 2 3 Vaginal dryness                              |
| 281. 0 1 2 3 Excessive menstrual flow                  | 291. 0 1 2 3 Vaginal itchiness                            |
| 282. 0 1 2 3 Scanty blood flow during periods          | 292. 0 1 2 3 Gain weight around hips, thighs and buttocks |
| 283. 0 1 2 3 Occasional skipped periods                | 293. 0 1 2 3 Excess facial or body hair                   |
| 284. 0 1 2 3 Variations in menstrual cycles            | 294. 0 1 2 3 Hot flashes                                  |
| 285. 0 1 2 3 Endometriosis                             | 295. 0 1 2 3 Night sweats (in menopausal females)         |
| 286. 0 1 2 3 Uterine fibroids                          | 296. 0 1 2 3 Thinning skin                                |

**Section 14** 30

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|---|---|
| 297. 0 1 2 3 Aware of heavy and/or irregular breathing  | 302. 0 1 2 3 Ankles swell, especially at end of day   |
| 298. 0 1 2 3 Discomfort at high altitudes               | 303. 0 1 2 3 Cough at night   |
| 299. 0 1 2 3 "Air hunger" or sigh frequently            | 304. 0 1 2 3 Blush or face turns red for no reason  |
| 300. 0 1 2 3 Compelled to open windows in a closed room | 305. 0 1 2 3 Dull pain or tightness in chest and/or radiate into right arm, worse with exertion |
| 301. 0 1 2 3 Shortness of breath with moderate exertion | 306. 0 1 2 3 Muscle cramps with exertion  |

**Section 15** 13

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|---|---|
| 307. 0 1 2 3 Pain in mid-back region                        | 310. 0 1 2 3 Cloudy, bloody or darkened urine |
| 308. 0 1 2 3 Puffy around the eyes, dark circles under eyes | 311. 0 1 2 3 Urine has a strong odor          |
| 309. 0 1 History of kidney stones (0=no, 1=yes)             |   |

**Section 16** 30

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|--|---|
| 312. 0 1 2 3 Runny or drippy nose  | 317. 0 1 2 3 Never get sick (0 = sick only 1 or 2 times in last 2 years, 1 = not sick in last 2 years, 2 = not sick in last 4 years, 3 = not sick in last 7 years)  |
| 313. 0 1 2 3 Catch colds at the beginning of winter  | 318. 0 1 2 3 Acne (adult)   |
| 314. 0 1 2 3 Mucus producing cough   | 319. 0 1 2 3 Itchy skin (Dermatitis)  |
| 315. 0 1 2 3 Frequent colds or flu (0=1 or less per year, 1=2 to 3 times per year, 2=4 to 5 times per year, 3=6 or more times per year)  | 320. 0 1 2 3 Cysts, boils, rashes   |
| 316. 0 1 2 3 Other infections (sinus, ear, lung, skin, bladder, kidney, etc.) (0=1 or less per year, 1=2 to 3 times per year, 2=4 to 5 times per year, 3=6 or more times per year) | 321. 0 1 2 3 History of Epstein Bar, Mono, Herpes, Shingles, Chronic Fatigue Syndrome, Hepatitis or other chronic viral condition (0 = no, 1 = yes in the past, 2 = currently mild condition, 3 = severe) |

KEY: 0=No, symptom does not occur                          2=Moderate symptom, occurs occasionally (weekly)  
 1=Yes, minor or mild symptom, rarely occurs (monthly)                          3=Severe symptom, occurs frequently (daily)