

- 7-8 hr sleep
- ④ lbs of hypercandy
- Zantac on a weekly
- good mood
- wigs
- low at 50
- memory

## **PATIENT INFORMATION**

Initial Appointment Date: \_\_\_\_\_

Patient Code: \_\_\_\_\_

Last Name: ABELA First Name: VIRGINIA Middle Name: MEDALLA  
 Birth Place: BACOLOD CITY Birth Date: MARCH 15, 1956 Age: 56  
 Permanent Address: 324 margarita st. magallanes village  
 City: makati State/Country: Philippines Zip: 1232  
 E-mail: gennyabela@yahoo.com Home Tel #: 852-5341 Cell #: 09173096407

\*Please  if appropriate in your case.

Gender:	Male	Female		
Handedness:	Right	Left	Ambidextrous	
Marital Status:	Single	Married	Divorced	Widowed
Student Status:	Full-time	Part-time	Not a student	Separated
Employment Status:	Full-time	Part-time	Not employed	Self-employed
				Retired

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_ Work Tel #: \_\_\_\_\_

### Responsible Party/Insured Person Information (If patient is under 18 years of age)

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
 Birth Place: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_  
 Permanent Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State/Country: \_\_\_\_\_ Zip: \_\_\_\_\_  
 E-mail: \_\_\_\_\_ Home Tel #: \_\_\_\_\_ Cell #: \_\_\_\_\_

### Patient Emergency Contact Information

Contact Name: BENJAMIN M. ABELA Home/Cell Phone #: \_\_\_\_\_  
 Relation: brother Work Phone #: 8128606

Patient's Name: VIRGINIA ABELA Today's Date: MARCH 7, 2013

How did you hear about Dr. Rex Gloria?

Paloma Garcia

### Family Medical History

\*Please  all diseases present among your family members.

\*\*For Relation please indicate if the disease is present in your parents, grandparents, siblings, aunts/uncles, nieces/nephews.

#### Cancer/Malignancy

##### Type of Cancer

Breast

Relation & age diagnosed

✓ aunt - 40

Colon/Rectal

Kidney (Renal cell)

Leukemia

Lung

Non-Hodgkin's Lymphoma

Ovarian

Pancreatic

Prostate

Skin (Basal cell)

Skin (Melanoma)

Thyroid

Uterus

Others

#### Stroke

##### Relation

Age Diagnosed

#### High Blood Sugar/Diabetes mellitus

##### Relation

✓ father grand-

Age Diagnosed

4?

#### High Cholesterol/Dyslipidemia

##### Relation

✓ father

Age Diagnosed

#### Osteoporosis

##### Relation

Age Diagnosed

#### Thyroid Disorder

##### Relation

✓ mother

Age Diagnosed

#### Depression/Bipolar Disorder

##### Relation

Age Diagnosed

#### Other Diseases

##### Relation

Age Diagnosed

Heart Disease (heart failure or ischemia manifesting as chest pain)/ Coronary Artery Disease (CAD as obstruction of artery/ies of the heart manifesting as chest pain and/or noted by 2D-echo and angiography)

##### Relation

Age Diagnosed

#### Heart Attack/Acute Myocardial Infarction

##### Relation

✓ father

Age Diagnosed

45

#### High Blood Pressure/Hypertension

##### Relation

✓ father

Age Diagnosed

45

Patient's Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

### Personal Health History

\*Please  all those present/appropriate in your case.

Known Allergies: (specify particular allergen and reaction upon exposure)

Medications: None  
Food: None  
Environmental: None  
(e.g., dust, smoke, pollen, etc.)

Immunization: (If yes, date of vaccination or booster shot)

BCG vaccine \_\_\_\_\_  
Diphtheria, Tetanus vaccine \_\_\_\_\_  
Hepatitis A vaccine \_\_\_\_\_  
Hepatitis B vaccine \_\_\_\_\_  
Human Papilloma Virus vaccine \_\_\_\_\_  
Influenza vaccine \_\_\_\_\_  
Measles, Mumps, Rubella vaccine \_\_\_\_\_  
Pneumococcal vaccine \_\_\_\_\_  
Polio vaccine \_\_\_\_\_  
Varicella vaccine \_\_\_\_\_  
Others \_\_\_\_\_

Past Medical History: (Have you EVER or RECENTLY been diagnosed with any of the following conditions?)

Acne	Cataract	High cholesterol
AIDS	Celiac Disease	HIV positive
Alcoholism	Chlamydia	Incontinence
Allergic rhinitis	Cold sores	Irritable bowel syndrome
Anemia	Constipation	Kidney disease
Angina pectoris	Crohn's Disease	Kidney stones
Anxiety	Dental problems	Liver disease
Arrhythmia (heart)	Depression	Lupus
Arthritis	Diabetes	Meniere's Disease
Asthma	Diverticulosis	Migraine
Atopic dermatitis	Eating disorder	Multiple sclerosis
Bleeding disorders	Emphysema	Parkinson's disease
Cancer	Epilepsy	Pacemaker
○ Breast	Fibromyalgia	Psychiatric disorder
○ Colon/Rectal	Glaucoma	Seizure disorder
○ Hodgkin Lymphoma	Goiter	Sleep apnea
○ Kidney	Gonorrhea	Sleep disorders
○ Leukemia	Gout	Stroke
○ Lung	Hearing loss	Suicide attempt
○ Non-Hodgkin Lymphoma	Heart burn/reflux	Thyroid disorder
○ Ovarian	(Ischemic) Heart disease	Tuberculosis
○ Pancreatic	Heart attack	Ulcerative colitis
○ Prostate	Hepatitis (type: _____)	Ulcer (gastric/duodenal)
○ Skin (Basal cell)	Hernia	Others: _____
○ Skin (Melanoma)	Herpes	
○ Testicular	High blood pressure	
○ Uterus		
○ Others: _____		

Patient's Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

List of Present Medications: (including over-the-counter drugs like vitamins or pain-relievers as well as supplements and natural medicines)

Medications/Supplements (ex. Paracetamol)	Dosage (ex. 500 mg)	Frequency (ex. once a day)	Duration of Use (ex. 1 month)	Reason for intake (ex. for pain)
- MN - URANA				
- Stem Enzyme				
- Napsil				
- Vit C				
- COQ 10				

Hospitalizations/Surgeries:

Year Admitted/Performed	Reason for hospitalization/ Surgical procedure performed	Outcome of hospitalization/surgery

Diagnostic Testing: (may provide/attach copies of recent lab results if available)

Diagnostic Exam	Date Performed	Results
12-lead ECG		
Blood chemistry		
Bone density		
Chest X-ray		
Complete Blood Count		
Colonoscopy		
Colposcopy		
Mammography		
PAP smear		
Spinal X-ray		
Others:		

Patient's Name: VIRGINIA ABELA Today's Date: March 22, 2013

### **Obstetric-Gynecologic History**

For WOMEN only: (Please  all those present/appropriate in your case; fill in required answer in the space provided)

1. Have you ever been found to have the following conditions?

- |  |  |  |     |    |
|--|--|--|-----|----|
| <input checked="" type="checkbox"/>                              | Pelvic organ prolapse                                    | i. Bladder prolapse (date/year diagnosed: _____) | Yes | No |
| <input checked="" type="checkbox"/>                              | ii. Uterine prolapse (date/year diagnosed: _____)        | Yes  | No  |    |
| <input checked="" type="checkbox"/>                              | iii. Vaginal prolapse (date/year diagnosed: _____)       | Yes  | No  |    |
| <input checked="" type="checkbox"/>                              | Vaginitis, frequent                                      | Yes  | No  |    |
| Date/year(s) diagnosed and treatment given:                      |  |  |     |    |
| <input checked="" type="checkbox"/>                              | Urinary tract infection, recurrent                       | Yes  | No  |    |
| Date/year(s) diagnosed and treatment given:                      |  |  |     |    |
| <input checked="" type="checkbox"/>                              | Endometriosis? (date/year diagnosed: _____)              | Yes  | No  |    |
| <input checked="" type="checkbox"/>                              | Fibroids in the uterus (date/year diagnosed: _____)      | Yes  | No  |    |
| <input checked="" type="checkbox"/>                              | Breast mass or cysts (date/year diagnosed: _____)        | Yes  | No  |    |
| <input checked="" type="checkbox"/>                              | Cysts in the ovaries (date/year diagnosed: _____)        | Yes  | No  |    |
| <input checked="" type="checkbox"/>                              | Impaired fertility (date/year diagnosed: _____)          | Yes  | No  |    |
| <input checked="" type="checkbox"/>                              | Pelvic Inflammatory Disease (date/year diagnosed: _____) | Yes  | No  |    |
| <input checked="" type="checkbox"/>                              | Sexual abuse, history of (date/year diagnosed: _____)    | Yes  | No  |    |
| <input checked="" type="checkbox"/>                              | Sexually Transmitted Infection                           | Yes  | No  |    |
| Specify type of STI, date/year(s) diagnosed and treatment given: |  |  |     |    |
| _____  |  |  |     |    |
| _____  |  |  |     |    |

2. With regards to your appearance, do you have or feel you have any of the following:

- |                                     |   |                           |     |    |
|-------------------------------------|---|---------------------------|-----|----|
| <input checked="" type="checkbox"/> | Appearance                              | i. Pale face              | Yes | No |
| <input checked="" type="checkbox"/> | ii. Reddish face                        | Yes                       | No  |    |
| <input checked="" type="checkbox"/> | iii. Aging appearance                   | Yes                       | No  |    |
| <input checked="" type="checkbox"/> | Body Hair                               | i. Less body hair         | Yes | No |
| <input checked="" type="checkbox"/> | ii. Excessive body hair                 | Yes                       | No  |    |
| <input checked="" type="checkbox"/> | Breasts                                 | i. Small breasts          | Yes | No |
| <input checked="" type="checkbox"/> | ii. Droopy, flaccid or deflated breasts | Yes                       | No  |    |
| <input checked="" type="checkbox"/> | iii. Enlarged breasts                   | Yes                       | No  |    |
| <input checked="" type="checkbox"/> | Excess body fat                         | i. On your breasts        | Yes | No |
| <input checked="" type="checkbox"/> | ii. On the belly                        | Yes                       | No  |    |
| <input checked="" type="checkbox"/> | iii. On the hips and buttocks           | Yes                       | No  |    |
| <input checked="" type="checkbox"/> | iv. On the thighs (cellulite)           | Yes                       | No  |    |
| <input checked="" type="checkbox"/> | Varicose veins                          | i. Painful varicose veins | Yes | No |
| <input checked="" type="checkbox"/> | ii. Painless varicose veins             | Yes                       | No  |    |

Patient's Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**Obstetric-Gynecologic History: For WOMEN (con't)**

**3. Menstrual History**

- Last menstrual period: \_\_\_\_\_/\_\_\_\_\_/2003 (approx.)
- Age during first menstruation:  
 < 12 years of age  
12-15 years old  
> 15 years of age
- Menstrual cycle:  
 Regular      Irregular  
 $\leq$  26 days      27-31 days       $\geq$  32 days
- Characteristics of bleeding:  
Light       Medium      Heavy
- Average number of days of bleeding: 7 days
- Average number of pads/tampons per day: \_\_\_\_\_ pads/tampons

**4. For the following questions, you may answer as follows:**

No/Never (0 instance)	Few or Sometimes (+/-)	Moderate or Regular (+)	Much or Often (++)	Extreme or Always (+++)
--------------------------	---------------------------	----------------------------	-----------------------	----------------------------

- Before your menstruation, have you ever had or felt any of the following:
  - i. Depression      Never      Sometimes      Regularly      Often      Always
  - ii. Painful swollen breasts      Never      Sometimes       Regularly      Often      Always
  - iii. Painful swollen belly      Never      Sometimes       Regularly      Often      Always
  - iv. Lower back pain       Never      Sometimes      Regularly      Often      Always
  - v. Irritability      Never       Sometimes      Regularly      Often      Always
  - vi. Anxiety       Never      Sometimes      Regularly      Often      Always
  - vii. Mood swings      Never       Sometimes      Regularly      Often      Always
  - viii. Ovulation pain (lower belly)      Never       Sometimes      Regularly      Often      Always
  - ix. Bleeding between periods      Never       Sometimes      Regularly      Often      Always
- During menstruation, have you ever had:
  - i. Violent cramps       Never      Sometimes      Regularly      Often      Always
  - ii. Extreme blood loss       Never      Sometimes      Regularly      Often      Always

**5. Are you still having your menstrual period?**

- If not, when was your last period?
- At what age did you have your *menopause*?

Yes      No  
Last menstrual period: \_\_\_\_\_/\_\_\_\_\_/2003 (approx.)  
< 48 years of age  
 48-52 years old  
> 52 years of age

**6. Have you ever complained of any of the following:**

- Excessive sweating
  - i. At night      Never       Sometimes      Regularly      Often      Always
  - ii. During the day      Never      Sometimes      Regularly      Often      Always
  - iii. When stressed      Never      Sometimes      Regularly      Often      Always

Patient's Name: VIRGINIA ABELA Today's Date: MARCH 22, 2013

**Obstetric-Gynecologic History: For WOMEN (con't)**

■ Changes in mood (ex. mood swings)	✓Never	Sometimes	Regularly	Often	Always
■ Changes in memory (ex. forgetfulness)	Never	Sometimes	✓Regularly	Often	Always
■ Hot flushes	Never	✓Sometimes	Regularly	Often	Always
■ Dryness of the skin	Never	Sometimes	✓Regularly	Often	Always
■ Dryness of the genital area	Never	Sometimes	✓Regularly	Often	Always
■ Loss of sexual desire/libido	Never	✓Sometimes	Regularly	Often	Always
■ Loss of sexual potency/orgasm	Never	✓Sometimes	Regularly	Often	Always
■ Painful intercourse	Never	✓Sometimes	Regularly	Often	Always
■ Abnormal vaginal discharge/odor	✓Never	Sometimes	Regularly	Often	Always
■ Abnormal vaginal bleeding	✓Never	Sometimes	Regularly	Often	Always
■ Vaginal itching	✓Never	Sometimes	Regularly	Often	Always
■ Vaginal dryness	✓Never	✓Sometimes	Regularly	Often	Always
■ Incontinence (urinary)	✓Never	Sometimes	Regularly	Often	Always

**7. History of Pregnancy**

- Total number of pregnancies: 1
- Number of live births: X
- Number of vaginal deliveries: X
- Number of cesarean sections: X
- Number of abortions: 1
- Number of miscarriages: X

**8. Are you sexually active?**

- How many partners in the last year? Yes ✓ No \_\_\_\_\_
- Last sexual contact (in days/months/years)? 2010
- Are you using contraception? Yes ✓ No \_\_\_\_\_
- If yes, kindly specify:  
Oral contraceptive pills  
Injectable contraceptives  
Contraceptive implant  
Intrauterine device  
Others: \_\_\_\_\_

**9. Have you ever had Pap smear done?**

- Abnormal Pap smear? Yes ✓ No \_\_\_\_\_
- Last Pap smear: 02 / 2013

**10. Have you ever had or done any of the following?**

- Hysterectomy (date performed: \_\_\_\_ / \_\_\_\_ / \_\_\_\_)
- Hormonal replacement therapy (date started: \_\_\_\_ / \_\_\_\_ / \_\_\_\_)  
Breast exam conducted by physician (date performed: 21 / 2013 result: normal)
- Self-breast exam (result: \_\_\_\_\_)

Patient's Name: VIRGINIA ABELA

Today's Date: March 22, 2013

### Lifestyle/Social History

Please  only those present/appropriate in your case. Fill in the answers in the blank space provided:

- I sleep 7 hours per night.
- I watch 5 hours of television per week.
- Exercise.
  - I do NOT exercise regularly.
  - I SOMETIMES exercise.
  - I REGULARLY exercise.
    - Type of exercise: badminton
    - Hours per week: 2
- Smoking.
  - I do NOT smoke cigarettes or tobacco.
  - I smoke OCCASIONALLY, averaging \_\_\_\_\_ sticks per month.
  - I smoke cigarette/s or tobacco REGULARLY, averaging 30 sticks or 1 packs per day for 40 years.  
I used to smoke but have already QUIT in year 2013 (*getting there down to about 4-5/day*)
- Water:
  - I drink more than or equal to 8 glasses of water per day.
  - I drink less than 8 glasses of water per day.
- Alcoholic beverages.
  - I DO NOT drink alcoholic beverages.
  - I drink alcoholic beverages ONLY during special occasions.
  - I drink an average of 12 glasses/shots a month, usually (type of beverage) beer
- Caffeinated beverages.
  - I DO NOT drink caffeinated beverages (*tea, coffee, soda, energy drinks*).
  - I drink caffeinated beverages (*tea, coffee, soda, energy drinks*).
    - I drink an average of \_\_\_\_\_ cups/glasses of tea per day.
    - I drink an average of 3 cups of coffee per day.
    - I drink an average of \_\_\_\_\_ cans/glasses of soda per day.
    - I drink an average of \_\_\_\_\_ "energy drinks" per day.
- Recreational/street drug use (*ex. ecstasy, cocaine, shabu, etc.*).
  - I have NEVER used and/or tried recreational/street drugs.
  - I have USED and/or TRIED the following:  
Drug: hallucinogens, etc. Last date of use: 1972
  - Drug: \_\_\_\_\_ Last date of use: \_\_\_\_\_
- I am AT PRESENT using the following:
  - Drug: \_\_\_\_\_ Last date of use: \_\_\_\_\_
  - Drug: \_\_\_\_\_ Last date of use: \_\_\_\_\_

### Travel.

I have travelled within the country recently.

Place/s of visit: Bacolod

Date of visit: Nov 2012

Patient's Name: VIRGINIA ABELA Today's Date: March 22, 2013

---

**Lifestyle/Social History (con't)**

▪ Travel: (con't)

I have travelled outside the country recently.

Place/s of visit:

Date of visit:

---

---

---

**LEGEND:**

No/Never (0 instance)	Few or Sometimes (+/-)	Moderate or Regular (+)	Much or Often (++)	Extreme or Always (+++)
--------------------------	---------------------------	----------------------------	-----------------------	----------------------------

**Nutrition:**

- |                                   |       |           |           |       |        |
|-----------------------------------|-------|-----------|-----------|-------|--------|
| ▪ I eat _____ meals per day.      | Never | Sometimes | Regularly | Often | Always |
| ▪ I cook my own meals.            | Never | Sometimes | Regularly | Often | Always |
| ▪ I eat fruits.                   | Never | Sometimes | Regularly | Often | Always |
| ▪ I eat vegetables.               | Never | Sometimes | Regularly | Often | Always |
| ▪ I eat meat.                     | Never | Sometimes | Regularly | Often | Always |
| ▪ I eat sweets, like chocolates.  | Never | Sometimes | Regularly | Often | Always |
| ▪ I use butter/margarine.         | Never | Sometimes | Regularly | Often | Always |
| ▪ I eat salty food.               | Never | Sometimes | Regularly | Often | Always |
| ▪ I eat at fast food restaurants. | Never | Sometimes | Regularly | Often | Always |

**Miscellaneous:**

- |                                      |     |    |
|--------------------------------------|-----|----|
| ▪ I have a living will.              | Yes | No |
| ▪ I have served in the military.     | Yes | No |
| ▪ I am an organ donor.               | Yes | No |
| ▪ I have received blood transfusion. | Yes | No |

**Vital statistics:**

- |   |  |
|---|--|
| ▪ Height: <u>5'2</u> in feet/inches               |  |
| ▪ Weight: <u>100kg</u> in kilogram <u>(50.79)</u> |  |
| ▪ Weight one year ago: <u>100kg</u> in kilogram   |  |
| ▪ Maximum weight: <u>110kg</u> in kilogram        |  |
| ▪ Minimum weight: <u>96</u> in kilogram           |  |
- when: 1997-80  
when: 2010

What affects your stress level the most?

anything & everything

Rate your average level of stress on the scale below with 10 being HIGHEST: (place an X)

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10

Patient's Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

### Hormonal Problems: A Review of Systems

\*There are 5 possible answers for each question. Please  what is appropriate in your case.

No or Never (0 instance)	Few or Sometimes (+/-)	Moderate or Regular (+)	Much or Often (++)	Extreme or Always (+++)
-----------------------------	---------------------------	----------------------------	-----------------------	----------------------------

#### SLEEP

Tendency of going late to bed and waking up late	Never	Sometimes	✓Regularly	Often	Always
Superficial, anxious, agitated sleep	Never	✓Sometimes	Regularly	Often	Always
Difficulty sleeping or falling asleep	Never	✓Sometimes	Regularly	Often	Always
Difficulty falling back to sleep after awakening at night	Never	✓Sometimes	Regularly	Often	Always
Easily waking up during the night	Never	✓Sometimes	Regularly	Often	Always
Poor dreaming	Never	✓Sometimes	Regularly	Often	Always
Jet lag problems	Never	✓Sometimes	Regularly	Often	Always
Restless leg syndrome at night ?	Never	Sometimes	Regularly	Often	Always
Light sleep	Never	✓Sometimes	Regularly	Often	Always
A need for a lot of sleep (more than nine hours)	Never	Sometimes	Regularly	Often	Always

#### ENERGY/VITALITY

Reduced vitality	Never	✓Sometimes	Regularly	Often	Always
Easily exhausted	Never	✓Sometimes	Regularly	Often	Always
Difficulty recovering when going late to bed	Never	✓Sometimes	Regularly	Often	Always
Constant tiredness/fatigue	✓Never	Sometimes	Regularly	Often	Always
Fatigue that increases with physical activity	✓Never	Sometimes	Regularly	Often	Always
Tired when waking up in the morning	✓Never	Sometimes	Regularly	Often	Always
Tired at rest, when not moving	✓Never	Sometimes	Regularly	Often	Always
Sleepy/lethargic/drowsy during the day	Never	✓Sometimes	Regularly	Often	Always

#### STRESS

Low resistance to stress	Never	✓Sometimes	Regularly	Often	Always
Excessive sensitivity to difficulties	✓Never	Sometimes	Regularly	Often	Always
Powerless or incompetent to cope with difficulties	Never	✓Sometimes	Regularly	Often	Always
Difficult recovery after a stressful situation	Never	✓Sometimes	Regularly	Often	Always
More tired in stressful situations	✓Never	Sometimes	Regularly	Often	Always
Easily confused or drowsy, especially when stressed	✓Never	Sometimes	Regularly	Often	Always

#### PERCEPTION OF SELF

Lower quality of life	✓Never	Sometimes	Regularly	Often	Always
Older-looking/feeling aged	Never	✓Sometimes	Regularly	Often	Always
Overweight (obesity)	✓Never	Sometimes	Regularly	Often	Always
Weight loss despite appetite	✓Never	Sometimes	Regularly	Often	Always
Deeply wrinkled face (forehead, eyes, mouth)	✓Never	Sometimes	Regularly	Often	Always
Pouches under the eyes	Never	✓Sometimes	Regularly	Often	Always

Patient's Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

	Never	Sometimes	Regularly	Often	Always
Sagging cheeks	✓	Sometimes	Regularly	Often	Always
Thin(ner) hair	✓	Sometimes	Regularly	Often	Always
Thin(ner) skin	✓	Sometimes	Regularly	Often	Always
Thin(ner) lips	✓	Sometimes	Regularly	Often	Always
Thin(ned) jaw bone	✓	Sometimes	Regularly	Often	Always
Loose skin folds under the chin	✓	Sometimes	Regularly	Often	Always
Bowed back (more than before)	✓	Sometimes	Regularly	Often	Always
Nails with longitudinal lines	✓	Sometimes	Regularly	Often	Always
Drooping triceps (muscle at the back of the arm)	✓	Sometimes	Regularly	Often	Always
Poorly (or less) muscled shoulders	✓	Sometimes	Regularly	Often	Always
Poorly (or less) muscled and wrinkled hands	✓	Sometimes	Regularly	Often	Always
Flabby or drooping belly	✓	Sometimes	Regularly	Often	Always
Poorly (or less) muscled hips	✓	Sometimes	Regularly	Often	Always
Poorly (or less) muscled buttocks	✓	Sometimes	Regularly	Often	Always
Drooping inner sides of the thighs	✓	Sometimes	Regularly	Often	Always
Fat cushions just above the knees	✓	Sometimes	Regularly	Often	Always
Body silhouette seems to sag down	✓	Sometimes	Regularly	Often	Always

## MOOD

Lack of aggressiveness	✓	Never	Sometimes	Regularly	Often	Always
Apathy	✓	Never	Sometimes	Regularly	Often	Always
Slow reaction / activity	✓	Never	Sometimes	Regularly	Often	Always
Easily distracted/Lack of concentration	✓	Never	Sometimes	Regularly	Often	Always
Tendency to isolate socially, to stay at home	✓	Never	Sometimes	Regularly	✓ Often	Always
Low self-esteem	✓	Never	Sometimes	Regularly	Often	Always
Loss of self-control	✓	Never	Sometimes	✓ Regularly	Often	Always
Sharp voice, screaming easily	✓	Never	Sometimes	✓ Regularly	Often	Always
Sharp verbal retorts	✓	Never	Sometimes	✓ Regularly	Often	Always
Mood swings	✓	Never	Sometimes	✓ Regularly	Often	Always
Irritable (aggressive)	✓	Never	Sometimes	✓ Regularly	Often	Always
Agitated	✓	Never	✓ Sometimes	Regularly	Often	Always
Anger climaxing in panic outbursts, rage	✓	Never	✓ Sometimes	Regularly	Often	Always
Abnormally nervous (tense)	✓	Never	✓ Sometimes	Regularly	Often	Always
Overly anxious (lack of serenity)	✓	Never	✓ Sometimes	Regularly	Often	Always
Depressed at morning	✓	Never	Sometimes	Regularly	Often	Always
Depressed during stressful situations	✓	Never	Sometimes	Regularly	Often	Always
Depressed the whole day	✓	Never	Sometimes	Regularly	Often	Always
Constantly depressed	✓	Never	Sometimes	Regularly	Often	Always

## GENERAL WELL-BEING

Poor memory (capacity to retain information)	Never	Sometimes	✓ Regularly	Often	Always
Poor concentration (capacity to remain attentive)	Never	Sometimes	✓ Regularly	Often	Always
Loss of order (carelessness)	Never	✓ Sometimes	✓ Regularly	Often	Always
Frequent complaints of being sick	✓ Never	Sometimes	✓ Regularly	Often	Always

Patient's Name: VIRGINIA ABELAToday's Date: March 22, 2013**HEAD, EYE, EAR, NOSE & THROAT**

	Never	Sometimes	Regularly	Often	Always
Light-headedness	✓				
Diffuse headache	✓	Never	Regularly	Often	Always
Migraine	✓	Never	Regularly	Often	Always
Nape pain	✓	Never	Sometimes	Often	Always
Hair loss on the upper scalp	✓	Never	Sometimes	Often	Always
Loss of outer third of eyebrow	✓	Never	Sometimes	Often	Always
Dry eyes	✓	Never	Sometimes	Often	Always
Dry mouth	✓	Never	Sometimes	Often	Always
Puffy face	✓	Never	Sometimes	Often	Always
Swollen lids	✓	Never	Sometimes	Often	Always
Swollen lips, tongue	✓	Never	Sometimes	Often	Always
Deafness/hearing loss	Never	✓	Sometimes	Often	Always
Tinnitus (ringing of the ears)	Never	✓	Sometimes	Often	Always
Colds (nasal congestion)	Never	✓	Sometimes	Often	Always
Hoarse voice	Never	✓	Sometimes	Often	Always

**HEART & LUNG**

	Never	Sometimes	Regularly	Often	Always
Slow heart rate	✓				
Fast heart rate (palpitations)	Never	✓	Regularly	Often	Always
Shortness of breath at rest	Never	✓	Sometimes	Often	Always
Shortness of breath when physically active	Never	✓	Sometimes	Often	Always
Poor recovery after physical exercise	Never	✓	Sometimes	Often	Always

**APPETITE/DIET/GASTROINTESTINAL**

	Never	Sometimes	Regularly	Often	Always
Poor appetite for meat	✓				
Attached to sugary/sweet food	✓	Never	Regularly	Often	Always
Attached to salty/spicy food	✓	Never	Regularly	Often	Always
Abdominal pain	✓	Never	Regularly	Often	Always
Intestinal spasm	✓	Never	Sometimes	Often	Always
Slow, difficult digestion (heavy stomach/bloatedness)	✓	Never	Sometimes	Often	Always
Constipation	✓	Never	Sometimes	Often	Always
Hemorrhoids	~	Never	Sometimes	Often	Always
Thin (underweight)	Never	✓	Sometimes	Often	Always
Fat (overweight)	✓	Never	Sometimes	Often	Always
Tendency to gain weight	✓	Never	Sometimes	Often	Always
Intolerance to fatty food	✓	Never	Sometimes	Often	Always
Intolerance to chocolates	✓	Never	Sometimes	Often	Always

Patient's Name: VIRGINIA ABELAToday's Date: March 22, 2013**URINARY**

	<input checked="" type="checkbox"/> Never	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Regularly	<input type="checkbox"/> Often	<input type="checkbox"/> Always
Difficulty to urinate	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning sensation while urinating	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent need to urinate during the night	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent need to urinate during the day	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urinary incontinence	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bladder infection, recurrent	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bedwetting as a child	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**MUSCULOSKELETAL**

	<input checked="" type="checkbox"/> Never	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Regularly	<input type="checkbox"/> Often	<input type="checkbox"/> Always
Muscles are less tonic (or appear loose)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscles with decreased volume	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscles with decreased strength	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle pain	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loose muscles on the arms	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loose muscle on the legs	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loose muscle on the belly	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thin muscles as a child	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thin bones as a child	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stiff joints in the morning when getting out of bed	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generalized joint pains	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint pains in the neck	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint pains in the middle back	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint pains in the lower back	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint pains in the fingers/ hand/ wrist	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint pains in the elbows	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint pains in the shoulders	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint pains in the toes/ foot/ ankles	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint pains in the knees	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint pains in the hips	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint pains worsened by cold or wet weather	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inflammatory rheumatism (arthritis)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers at the ankles or toes	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carpal tunnel syndrome (tingling fingers)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**DERMATOLOGIC**

	<input checked="" type="checkbox"/> Never	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Regularly	<input type="checkbox"/> Often	<input type="checkbox"/> Always
Pale skin	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry skin on the face	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry skin on the elbows	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry skin on the legs	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patient's Name: VIRGINIA ABELAToday's Date: March 22, 20B

	Never	Sometimes	Regularly	Often	Always
Diffuse hair loss	✓				
Slow growing hair	✓				
Poor perspiration	✓				
Yellow palms	✓				
Brittle fingernails	✓				
Slow growing nails	✓				
Broad brown spots of excessive pigmentation	Never	Sometimes	Regularly	Often	Always
Broad white spots of depigmentation (vitiligo)	✓	Sometimes	Regularly	Often	Always
Dandruff	✓	Sometimes	Regularly	Often	Always
Itching scalp	✓	Sometimes	Regularly	Often	Always
Peeling or itching red or white spots on your body (eczema)	✓	Sometimes	Regularly	Often	Always
Skin which burns easily in the sun	✓	Sometimes	Regularly	Often	Always

**ENDOCRINE**

	Never	Sometimes	Regularly	Often	Always
Intolerance to cold	✓				
Sensitivity to cold	✓				
Feeling cold in the evening	✓				
Cold hands	✓				
Cold feet	✓				
Increase need for blankets during cold nights	✓				
Poor blood circulation on extremities	✓				
Swollen eyelids	✓				
Swollen hands	✓				
Swollen feet	✓				
Intolerance to heat	✓	Sometimes	Regularly	Often	Always
Sensitivity to heat	✓	Sometimes	Regularly	Often	Always
Permanent feeling of excessive heat	✓	Sometimes	Regularly	Often	Always
Continuous & excessive perspiration over the whole body	✓	Sometimes	Regularly	Often	Always

**IMMUNOLOGIC/HEMATOLOGIC**

	Never	Sometimes	Regularly	Often	Always
Poor health	✓				
Frequent infections	✓	Sometimes	Regularly	Often	Always
Food allergies	✓	Sometimes	Regularly	Often	Always
Skin allergies	✓	Sometimes	Regularly	Often	Always
Nose, throat, ear allergies	✓	Sometimes	Regularly	Often	Always
Suffering from asthma	✓	Sometimes	Regularly	Often	Always
Difficult wound healing	✓	Sometimes	Regularly	Often	Always
Easy bruising	✓	Sometimes	Regularly	Often	Always

Patient's Name: VIRGINIA ABELA

Today's Date: March 22, 2013

### Review of Systems

\*Please  only those symptoms or conditions that you CURRENTLY have or have RECENTLY experienced.

\*\*Fill in the answers in the blank space provided.

#### General

Fever  
Chills  
 Night sweats  
Easy fatigability  
Loss of appetite  
Weight loss (unexplained)  
Weight gain (rapid)

#### Neck

Anterior neck mass  
Swollen glands  
Nape pain  
 Neck stiffness

Flatulence

Yellowing of the skin/sclerae  
Other abdominal complaints:

#### Skin

Bothersome rash  
Excessive skin dryness  
Excessive sweating  
Itching  
Nail changes  
Inexplicable hair loss  
Inappropriate hair growth  
Other skin problems:

#### Chest/Lungs

Chronic cough  
Hemoptysis  
Wheezing  
Snoring  
 Difficulty breathing when supine  
 Difficulty breathing when upright

#### Genito-Urinary

Pain or burning on urination  
Passage of sandy urine  
Blood in urine  
Frequent urination  
Intermittency  
Dribbling  
Urgency  
Incontinence

#### Breast

Breast mass  
Breast tenderness  
Nipple pain  
Nipple discharge  
Skin changes (*peau d'orange*)

#### For MEN

Discharge from penis  
Painful sore/s on penis  
Painless sore/s on penis  
Lump/pain in testicle  
Prostate problem

#### Eyes-Ears-Nose-Throat

Blurring of vision  
Loss of vision  
Blank spots in vision  
Flashes of light  
Eye pain  
Eye redness  
Excessive tearing  
 Hearing loss  
Ear pain  
Ear discharge  
Ringing in the ears (persistent)

#### Chest/Heart

Chest pain on exertion  
Chest pain at rest  
 Palpitations  
Irregular heart beat  
 Shortness of breath on exertion  
Shortness of breath at rest  
Waking up short of breath  
Ankle/leg swelling  
 Leg/calf pain/cramps  
Other heart complaints:

#### For WOMEN

Absence of menstruation  
Irregular menses  
Hot flashes  
Vaginal discharge  
Vaginal infection  
Vaginal bleeding  
Pelvic pain

Others:

Frontal headache  
Sinus problems  
Nose bleed  
Runny nose (rhinorrhea)  
Persistent sneezing (rhinitis)  
  
Pain on swallowing  
Difficulty swallowing  
(obstructed)  
 Hoarseness/voice change  
Mouth sores  
Mass/growth in the mouth

#### Gastro-Intestinal

Abdominal pain  
Abdominal mass  
 Bloatedness/fullness  
Nausea  
Vomiting  
Diarrhea  
Constipation  
Blood in vomitus  
Blood in stools

#### Musculoskeletal

Upper back pain/stiffness  
Lower back pain/stiffness  
Decreased range of motion  
 Joint stiffness  
Joint pain  
Specify joint: \_\_\_\_\_  
  
Joint redness  
Specify joint: \_\_\_\_\_

Patient's Name: VIRGINIA ABELA Today's Date: March 22, 2013

**Review of Systems (con't)**

\*Please  only those symptoms or conditions that you CURRENTLY have or have RECENTLY experienced.

\*\*Fill in the answers in the blank space provided.

Joint swelling  
Specify joint: \_\_\_\_\_

✓ Muscle pain/cramps  
Specify muscle group: legs: calves

✓ Calf pain/tenderness  
Muscle weakness  
Specify muscle group: \_\_\_\_\_

Shoulder problems  
Elbow problems  
Wrist problems  
Hip problems  
Knee problems  
Ankle problems

Others:  
\_\_\_\_\_

**Hematologic**

Easy bruising  
Spontaneous hematoma  
Prolonged bleeding  
Abnormal clotting  
Pallor  
Epistaxis/nose bleed  
Gum bleed

**Neurologic**

Headache  
o Severe  
o frequent  
Migraine  
Dizziness  
Fainting spells  
Seizure/convulsions  
Tremors  
Slurring of speech  
Difficulty speaking  
Drooping of one side of the face  
Weakness of one side of the body  
Incoordination  
Forgetfulness  
Memory loss

Urinary incontinence  
Bowel incontinence  
Others: \_\_\_\_\_

**Psychiatric**

Alcohol dependence  
Anxiety/nervousness  
Delusions  
Depression  
Fearfulness  
Hallucinations  
Hypersomnia  
Inability to concentrate  
Insomnia  
✓ Irritability  
Mood swings  
Panic attacks  
Suicidal thoughts  
Suicidal planning  
Suicidal attempts  
Sexual problems  
Others: \_\_\_\_\_

**Endocrinologic**

Short stature  
Fine brittle hair  
✓ Cold intolerance  
Heat intolerance  
Excessive thirst  
Frequent painless urination  
Frequent feeding/hunger pangs  
Erectile dysfunction  
Others: \_\_\_\_\_

WHAT DO YOU THINK IS HAPPENING TO YOUR HEALTH?

weak lungs  
stomach: gassy/painful

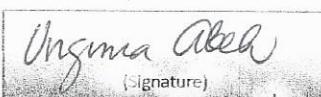
WHAT DO YOU FEEL YOU NEED TO DO IN ORDER TO RECOVER?

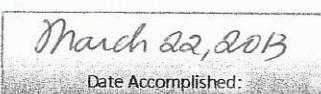
quit smoking

HOW DO YOU THINK WE CAN HELP YOU?

passent suitable  
lets to check  
state of health  
(endoscopy, etc?)

I certify that the information on this form is correct to the best of my knowledge.  
I will not hold my doctor or any member of the staff responsible for any errors or omissions that I may have committed while completing this form.

  
(Signature)

  
Date Accomplished:

NAME : VIRGINIA ABEZADATE : March 22, 2013

Please answer by checking the food you eat.

## MILK PRODUCTS

- Milk  
 Buttermilk  
 Yogurt

- Cheese  
 Cottage Cheese  
 Butter

## SUGAR

- White sugar, cane sugar  
 Cake  
 Honey

- Chocolates  
 Candies  
 Biscuits

## FRUITS

- Orange  
 Apple  
 Grapes

- Banana  
 Watermelon  
 Others: \_\_\_\_\_

Are they ripe when you eat them? *yes*

## VEGETABLES

- Do you eat them raw?  
 Cooked in oil or butter?

- As canned vegetables?  
 Boiled?

## CEREALS

- Corn Flakes  
 Muesli

## BREAD

- White bread  
 Whole grain bread

## PASTAS

- White pasta  
 Brown pasta

- Sunny-side up

## EGG

- Scrambled  
 Raw

- Chicken

## MEAT

- Pork  
 Beef

Do you eat them:

- Grilled (Barbeque)  
 Cooked in butter or in oil  
 In the oven  
 Raw

- Boiled or steam  
 Butcher's meat  
 (Salami, Smoked ham)  
 Canned meat

- Crab  
 Shrimps

- Raw  
 Boiled or steam

## SEAFOODS

- Fish  
 Shellfish

- Raw  
 Boiled or steam

Do you eat them:

- Grilled (Barbeque)  
 Cooked in butter or in oil  
 In the oven

- Raw  
 Boiled or steam

## ORGANIC FOOD

Please indicate: \_\_\_\_\_

Please answer by checking what you drink.

What do you drink?

SUGAR DRINKS

- Softdrink  
 Tonic

CAFFEINATED DRINKS

- Real coffee  
 Real tea

- Cola  
 Coffee derivatives

ALCOHOLIC DRINKS

- Beer

- Other: wine, brand

STRONG ALCOHOLS

- Whisky  
 Cognac

- Vodka

WINE

- Red  
 White

- Mineral/sparkling

WATER

- Distilled  
 Tap

What do you eat for:

BREAKFAST

	TIME:		
<input checked="" type="checkbox"/>	Meat smoked or dried (bacon, ham, etc.)	<input type="checkbox"/>	Cheese
<input type="checkbox"/>	Eggs	<input type="checkbox"/>	Yogurt
<input type="checkbox"/>	Milk		
<input type="checkbox"/>	Fruit		
Please indicate: <u>orange, canned salmon</u>			
<input checked="" type="checkbox"/>	Water	<input type="checkbox"/>	Fresh fruit juice
<input type="checkbox"/>	Carbonated drinks	<input type="checkbox"/>	Tea
<input checked="" type="checkbox"/>	Coffee		

MID-MORNING

	TIME:		
<input type="checkbox"/>	Fruit	<input type="checkbox"/>	Sweets (pastries, chocolates)
<input type="checkbox"/>	Bread	<input type="checkbox"/>	Salty foods (chips)
Please indicate: _____			
<input type="checkbox"/>	Water	<input type="checkbox"/>	Fresh fruit juice
<input type="checkbox"/>	Carbonated drinks	<input type="checkbox"/>	Tea
<input type="checkbox"/>	Coffee		

MID-AFTERNOON

	TIME:		
<input type="checkbox"/>	Fruit	<input type="checkbox"/>	Sweets (pastries, chocolates)
<input type="checkbox"/>	Bread	<input type="checkbox"/>	Salty foods (chips)
Please indicate: _____			
<input checked="" type="checkbox"/>	Water	<input type="checkbox"/>	Fresh fruit juice
<input type="checkbox"/>	Carbonated drinks	<input type="checkbox"/>	Tea
<input type="checkbox"/>	Coffee		

LUNCH

	TIME:		
<input type="checkbox"/>	Salad	<input type="checkbox"/>	Rice
<input checked="" type="checkbox"/>	Cheese	<input type="checkbox"/>	Meat
<input type="checkbox"/>	Pasta	<input type="checkbox"/>	Potato
<input type="checkbox"/>	Fish	<input checked="" type="checkbox"/>	Bread (sandwiches)
<input type="checkbox"/>	Meat (smoked or dried)	<input type="checkbox"/>	Fruit
Please indicate: _____			
<input checked="" type="checkbox"/>	Water	<input type="checkbox"/>	Fresh fruit juice
<input type="checkbox"/>	Carbonated drinks	<input type="checkbox"/>	Tea
<input type="checkbox"/>	Coffee		

DINNER

	TIME:		
<input type="checkbox"/>	Salad	<input checked="" type="checkbox"/>	Rice
<input type="checkbox"/>	Cheese	<input checked="" type="checkbox"/>	Meat
<input checked="" type="checkbox"/>	Pasta	<input checked="" type="checkbox"/>	Potato
<input type="checkbox"/>	Fish	<input type="checkbox"/>	Bread (sandwiches)
<input type="checkbox"/>	Meat (smoked or dried)	<input type="checkbox"/>	Fruit
Please indicate: _____			
<input checked="" type="checkbox"/>	Water	<input type="checkbox"/>	Fresh fruit juice
<input type="checkbox"/>	Carbonated drinks	<input type="checkbox"/>	Tea
<input type="checkbox"/>	Coffee		

## QUESTIONNAIRE: POSSIBLE EXPOSURE TO TOXIC CHEMICALS

Please answer the following questions pertaining to possible effects on your body from indoor and outdoor pollution.

### YOUR HOME:

Where do you live?

- In a town  
 In a city

- In a province

Is there much traffic pass your home?

- Cars  
 Trucks  
 Buses

Do you live on a corner or near a corner?

near a corner

Is there in the neighborhood of your home, is there a?

- A bus stop  
 Traffic lights  
 A main road How far? \_\_\_\_\_  
 Public works  
 A railway  
 Trams  
 An airfield  
 A school  
 A gas station  
 An electricity substation  
 High tension cables How far? \_\_\_\_\_  
 A cell site  
 A stream or a river Does it smell bad? \_\_\_\_\_  
 An industrial site  
 A warehouse Of what? \_\_\_\_\_  
 Factory(ies) Of what? \_\_\_\_\_  
How far? \_\_\_\_\_  
Do they pollute? \_\_\_\_\_

Are you troubled by someone in your neighborhood who burns his waste material, wood, plastics, garden rubbish? NO

What about barbecue? NO

Is the road pass your house made with paving-stones or with asphalt?

asphalt

Are there near your home:

- Pastures  
 Fields  
 Greenhouse

- Orchards  
 Cultivation of flowers  
 Cultivation of vegetables

Do they spray pesticides? \_\_\_\_\_ How often? \_\_\_\_\_

Do you live:

- In a house  
 Isolated  
 In a row



In an apartment  
In a condominium

Which floor? \_\_\_\_\_  
Which floor? \_\_\_\_\_

Is your home:

- Old  
 New

How long have you been living there? 27 yrs

And where before that? W/ parents in basement

How long have you lived there? 16 yrs

Do you much wood work in your home?

- No  
 Yes

If yes, Where?

- Walls  
 Floor  
 Ceiling  
 Furniture

Has the wood been treated with preservative?

- Sadolin  
 Linitop  
 Xylamon (xyladecor)

If yes, when? floor - 2012

Has painting been carried out in your home during the last few years?

- No  
 Yes

With what?

- Oil paint  
 Latex  
 Water soluble paint  
 Acrylic paint

Do you often use:

- White flower (eucalyptus scent)  
 Thinners  
 Turpentine

The floor coverings in your home, what are they?

- Parquet or wood strip
  - Vinylis
  - Novilon
  - Linoleum
  - Stone (granite, marble)
  - Fitted carpet
  - Synthetic or wood

Where?

bedroom, stairs

Are the walls covered?

- No  
Yes, with

<input checked="" type="checkbox"/>	Paper
<input type="checkbox"/>	leather
<input type="checkbox"/>	Fabric
<input checked="" type="checkbox"/>	Glass

Where?

Do you have:

- Plywood furniture
  - Solid waste furniture

What do you have on your bedroom floor? parquet; Carpet On the walls? wallpaper

Are your blankets or quilts synthetic?      Mattress?

Matress?

Pillows?

Do you have plastic lampshades?

- No  
 Yes

What are the curtains in your home made of?

- Synthetic  
 Cotton  
 Velvet  
 Others:

Where?

for all areas  
bedroom

Is your bedroom:

- Immediately under the roof  
 Under an attic

Has the woodwork of the roof been treated with preservatives? yes Which one? antiseptics

Is your garage:

- Included in the house  
 Separated from the house

Is your garage sufficiently separated from the dining room?

Is your home heated with:

Central heating  
Electric heating  
Gas radiators

Open fireplace  
Oil-fired

How many? \_\_\_\_\_

Do you cook by:

Electricity  
Gas

Can you ventilate your kitchen well?

*yes*

For water containers, do you use:

Plastic container  
Glass container

For drinking water, do you use:

Mineral  
Tap

Potable  
Not Potable

High in:

Chlorine  
Calcium  
Sodium

Do you use it for:

Tea, coffee  
Boiling food (vegetables, root crops)

Do you smoke? *yes*

How many sticks per day?

*4-7 sticks/day  
trying to quit*

How about:

Your spouse  
Your children  
Others around you

Do you eat:

Little  
Enough  
Much

Do you cook your food on:

Low temperature  
High temperature

Do you often eat in restaurants? *No*

Are you sensitive to:

Cleaning products  
Perfume  
Bee wax

Ammonia  
Bleach  
Others: \_\_\_\_\_

Do you suffer or have suffered from:

- Hay fever  
 Skin allergies  
 Food allergies

Do you have animals at home? \_\_\_\_\_

- Cat  
 Dog

How many?

- 

Bird

Others: Turtle

What breed, type or species? Cats & 1 dog adopted strays, 2 labradors

Do you have a second residence? No

- A chalet  
 Caravan

Where? \_\_\_\_\_

- Wood construction  
 A country house

How do you feel by the: good

- Sea?  
 Mountains?

How many miles do you drive an automobile a year? 40

What type?

- SUV  
 Sedan

Sports car

Do you ride a:

- Bicycle

Motorcycle

Do you use cosmetics? yes

Do you use:

- Hair laquer  
 Dye

Which one(s)? Lipstick, blush, foundation,  
eyeliner pencil, eye liner,

Do you know the composition? No

Do you wear:

- Many synthetic garments  
 Shoes with synthetic soles

Rubber shoes  
 A digital watch

Do you have any:

- Dental fillings    How many? \_\_\_\_\_  
 Amalgams

## PAST AND PRESENT

What is or was your profession? interior designer, chef

Where do or did you work?

- At home  
An industry  
In a factory

- In a company - bakery  
Somewhere else

Since how long do (did) you work there? 1985-2003 And before? \_\_\_\_\_

Do (did) you work in a:

- City  
Province

Do (did) you do a:

- Manual work  
Administrative work  
Others

Is there, near your work:

- Heavy traffic  
A garage  
A main road

- Petron station  
A factory (ies)  
An industrial estate  
A river or steam

Do (did) you work with a:

- computer  
Photocopy machine

Is (was) there a sufficient ventilation?

- Natural  
Airconditioning

Do (did) you suffer from it? \_\_\_\_\_

What is (are) the floor coverings in your office/workplace?

- Fitte carpet  
Novilon  
Parquet or wood strip  
Linoleum

- Atone  
Synthetic wood  
Vinyl

Are the walls covered with vinyl paper? \_\_\_\_\_

Do (did) you work with a dangerous chemicals?

Do you use:

- Thinner  
White spirit

- Turpentine  
Others: \_\_\_\_\_

Do (did):

- You smoke at work  
People smoke near you

Were you exposed to fumes? yes

Do you think you suffer from toxic in your:

- Environment  
Home  
Work

Do you think pollution is threat to your health?

yes

Are you well aware of the problems caused by pollution?

No

**REMARKS:**