MEDICAL HISTORY:

1. Have you had or are you currently being treated for any illnesses/conditions? Mark all that apply:

☐ Arthritis ☐ Asthma ☐ Backaches ☐ Depression ☐ Diabetes ☐ Eating Disorder
☐ Hay Fever ☐ Headaches ☐ High Blood Pressure ☐ High Cholesterol ☐ Pregnancy ☐ Other

Other, please list: _____

2. Have you ever taken tetracyclines, other broad spectrum antibiotics, or cortisone type drugs for 2 months or longer, or 4 or more times in one year? ☐ Yes ☐ No

3. Have you had major surgery? ☐ Yes ☐ No

If yes, please list. _____

_____

4. Do you have a family history of:

☐ Alcoholism ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ High Cholesterol ☐ Kidney Disease
☐ High Blood Pressure ☐ Obesity ☐ Osteoporosis ☐ Respiratory Conditions ☐ Other

Other, please list: _____

5. Any known food allergies?

☐ Milk ☐ Wheat ☐ Corn ☐ Nuts ☐ Seafood ☐ Other ☐ None

Other, please list: _____

6. Do you have other allergies? ☐ Yes ☐ No

If yes, please list: _____

_____

7. Do you have any known food sensitivities? Lactose intolerance, gluten intolerance etc. ☐ Yes ☐ No

8. Do you have any amalgam fillings? ☐ Yes ☐ No If yes, how many? _____

9. Do you have any symptoms of gastrointestinal distress: gas, bloating, constipation etc.? ☐ Yes ☐ No

10. Are you currently on any medications? Birth control, thyroid, steroids, aspirin, other? ☐ Yes ☐ No

If yes, please list: _____

_____

11. Are you currently taking any supplements? ☐ Yes ☐ No

If yes, please list: _____

_____

12. What is your blood type? ☐ A Pos ☐ A Neg ☐ B Pos ☐ B Neg ☐ AB Pos ☐ AB Neg ☐ O Pos ☐ O Neg

PERSONAL HABITS:

13. What activities do you like / regularly participate in?

_____

_____

14. Do you like to cook? ☐ Yes ☐ No ☐ Sometimes

15. How often do you eat out? _____

16. Do you have cultural/ethnic food preferences? ☐ Yes ☐ No

If yes, what kind? _____

17. Please mark if applicable. ☐ Lacto/Ovo ☐ Vegetarian ☐ Vegan ☐ N / A

18. How many glasses of water do you drink/day? _____

19. Do you consume beer, wine, and/or other alcohol? ☐ Beer ☐ Wine ☐ Other Alcohol ☐ None

20. Do you smoke or use tobacco products, i.e. chew or snuff?? ☐ Yes ☐ No