Date_____ Dr._____ Patient_____ #_____

HEALTH EVALUATION QUESTIONNAIRE

1. How many cups of REGULAR coffee do you drink @ breakfast? _____
   @ lunch? _____
   @ dinner? _____
   in between or at other times? _____

2. How many cups of de-caffeinated coffee do you drink @ breakfast? _____
   @ lunch? _____
   @ dinner? _____
   in between or at other times? _____

3. How many regular pops _____ or diet pops _____ do you drink per day?

4. How many cups of tea do you drink per day? _____
   What type of tea do you drink? _____

5. How many teaspoons of regular sugar do you use in each cup of tea or coffee? _____

6. Do you use artificial sweetener? Yes/No
   What type? _____
   Do you use honey? Yes/No

7. Do you usually eat some type of dessert after lunch? Yes/No
   after dinner? Yes/No
   Do you usually eat some type of dessert for snacks or other times during the day? Yes/No

8. What things do you eat for snacks?_____

9. What do you usually eat for breakfast? _____

10. What do you usually eat for lunch?_____

11. What do you usually eat for dinner?_____

12. What hours do you work out of the house (e.g. 8 a.m. - 5 p.m.) _____

13. What hours do you usually sleep (e.g. 11 p.m. - 6 a.m.) _____

14. How many cocktails or alcoholic drinks do you usually have @ lunch? _____
    @dinner? _____
    at other times? _____

15. What type of alcohol do you prefer?_____

16. How many social functions do you attend per month in which you drink alcoholic beverages? _____

17. How many drinks do you usually have at each function? _____

18. Do you usually salt your food during cooking? Yes/No

19. Do you usually salt foods at the table while eating? Yes/No

20. Do you sometimes salt your food at the table before tasting it? Yes/No

21. Do you use monosodium glutamate ("Accent")? Yes/No

22. Do you have softened water at home? Yes/No
    at work? Yes/No

23. How many packs of cigarettes do you smoke per day? _____

24. How often do you go one pack over? _____

Date_____ Dr._____ Patient_____ #_____

25. How many cigars do you smoke per day? _____

26. Do you smoke a pipe? _____

27. How many times per week do you eat luncheon meats? _____

28. How many times per week do you eat hot dogs? _____

29. Do you often eat charcoal-grilled meats in restaurants or on your barbecue grill? _____

30. How many times per week do you eat bacon? _____

31. Do you usually eat canned or fresh or frozen vegetables? Canned/Fresh/Frozen

32. Name the prescription drugs which you take regularly._____
Birth control pills?_____

33. Name the non-prescription drugs which you take regularly._____

34. Do you work/live in an environment of fumes, chemicals, gases, etc.? Yes/No
What?_____

35. Which of your relatives have/had any of the following problems (indicate by number):

_____ Father	_____ Sisters	_____Sons	_____ Father's mother
_____ Mother	_____ Uncles	_____Daughters	_____ Mother's father
_____ Brothers	_____ Aunts	_____Father's father	_____ Mother's mother

(**1**)Cancer (**2**)Blood sugar (Diabetes) (**3**)Arthritis (**4**)Heart disease, high blood pressure (**5**)Alcohol problems
(**6**)Spastic colon, colitis (**7**)Headaches (**8**)Nerve, mental problem (**9**)Gallbladder or urinary (**10**)Good health
You may list more than one number for each relative.

36. Do you perform any regularly scheduled exercise? Yes/No

37. Is there a lot of exercise in your job? Yes/No
What?_____

38. What is the name of the hair shampoo that you use? _____

39. Do you have a "permanent", "cold-wave" or dye treatment in your hair now? Yes/No

40. Do you often feel "bloated" or excessively full after eating? Yes/No

41. Do you usually drink liquids with your meals? Yes/No
How many glasses/cups? _____

42. Do you have a lot of stomach gas, belching? Yes/No

43. Do you have a lot of bowel gas, flatulence? Yes/No

44. How often do you move your bowels?
several x/day 1-2x/day 3-4x/week 1-2x/weekly once in 10-15 days once/month

45. Is your stool usually loose or formed consistency? L / F

46. Indicate the usual color of your stool: white yellow light brown brown dark brown black

47. Are there usually undigested food particles in your stool? Yes/No

48. How many glasses of milk do you drink daily? _____

49. Which vitamins do you take?_____

Patient Signature_____