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**Lifestyle-Twenty
 Survey**

3/4/2018
 s_lifestyle.a03.docx

Name:

Date:

	Strongly Disagree	Disagree	Neutral or Not Applicable	Agree	Strongly Agree
1) I have reviewed books, videos and webcasts and other materials regarding health and holism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2) I take gentle walks, do yoga, or do other exercise 1-3x/week	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3) I sleep at least 7 - 8 hours per night and wake up feeling well rested. My bedroom is pitch dark.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4) I drink at least 8 cups of quality water/day. I have a filter or other source of quality water.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5) I believe spirit, community, connection, laughter and music are necessary for optimal health and healing, and feel this dimension is addressed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6) I eat organic only: soy, spinach, strawberries, peppers, other fruits & veggies, animal products.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7) I have one vegetarian/raw/juice meal/day per week.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8) I eat healthy oils, nuts and seeds: almond, chia, coconut, flax, olive, sesame and walnut. I know how to read labels regarding fats.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9) My primary sweeteners are fresh fruit, honey, maple syrup and coconut sugar. I avoid artificial sweeteners, corn syrup, fructose, sugar-sweetened soda and "diet" drinks. I understand how to read food labels regarding carbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10) I have replaced table salt with Himalayan Salt or celtic salt. My diet contains an Iodine source.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11) I have reduced or eliminated tuna, swordfish from my diet. I only eat wild salmon.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12) I have reduced or replace cosmetics and household chemicals with organic sources	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13) I am consistent in my use of pharmaceutical medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14) I have eliminated all hydrogenated oils and other toxic additives. I know how to read food labels regarding additives.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15) I have eliminated or reduced fruit juice.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16) I have reduced or eliminated caffeine.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17) I do not smoke cigarettes, cigars or vapes.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18) I have reduced or eliminated aluminum and non-stick cookware.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19) I have eliminated fluoride from my toothpaste and water. My oral hygiene and status are acceptable.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20) I am aware of EMF's and am cautious with my phone, router and other wireless technology.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Name & Date:

For each of your symptoms, check off the best answer. Add total score and record in the space indicated at the end of each section, and then calculate the total score on page 2.

SECTION A: HISTORY

A1	Have you ever taken tetracyclines or other antibiotics for acne	No <input type="checkbox"/> 0	Yes <input type="checkbox"/> 35
A2	Have you, at any time in your life, taken other "broad spectrum" antibiotics* for sinus, respiratory, urinary or other infections for 2 months or longer, OR 4 or more times in a 1-year period?	No <input type="checkbox"/> 0	Yes <input type="checkbox"/> 35
A3	Have you taken a broad spectrum antibiotic drug *--even a single course?	No <input type="checkbox"/> 0	Yes <input type="checkbox"/> 8
A4	Have you, at any time in your life, been bothered by persistent prostatitis, vaginitis or other problems affective your reproductive organs?	No <input type="checkbox"/> 0	Yes <input type="checkbox"/> 25
A5	Have you been pregnant...	No <input type="checkbox"/> 0	1 time <input type="checkbox"/> 1 2 or more times <input type="checkbox"/> 5
A6	Have you taken birth control pills...	No <input type="checkbox"/> 0	for 6 months to 2 years <input type="checkbox"/> 8 for more than 2 years <input type="checkbox"/> 15
A7	Have you taken prednisone, Decadron or other cortisone-type drugs...	No <input type="checkbox"/> 0	for 2 weeks or less? <input type="checkbox"/> 6 for more than 2 weeks? <input type="checkbox"/> 15
A8	Does exposure to perfumes, insecticides, auto exhaust, cleaners and other chemicals provoke any symptoms...	No <input type="checkbox"/> 0	mild <input type="checkbox"/> 5 moderate to severe <input type="checkbox"/> 20
A9	Are your symptoms worse on damp, muggy days or in moldy places?	No <input type="checkbox"/> 0	Yes <input type="checkbox"/> 20
A10	Have you had athlete's foot, ring worm, "jock itch" or other chronic infections of the skin or nails? Have such infections been...	No <input type="checkbox"/> 0	Mild to moderate <input type="checkbox"/> 10 Severe or persistent? <input type="checkbox"/> 20
A11	Do you crave sugar?	No <input type="checkbox"/> 0	Yes <input type="checkbox"/> 10
A12	Do you crave breads?	No <input type="checkbox"/> 0	Yes <input type="checkbox"/> 10
A13	Do you crave alcoholic beverages?	No <input type="checkbox"/> 0	Yes <input type="checkbox"/> 10
A14	Does tobacco smoke really bother you?	No <input type="checkbox"/> 0	Yes <input type="checkbox"/> 10

Total Score Section A

*Including ampicillin, amoxicillin, Augmentin, Bactrim, Ceclor, Keflex, and Septra.

SECTION B: MAJOR SYMPTOMS

	No	Occ or mild	Frequent and/or Mod. severe	Severe and/or disabling
B1	<input type="checkbox"/> 0	<input type="checkbox"/> 3	<input type="checkbox"/> 6	<input type="checkbox"/> 9
B2	<input type="checkbox"/> 0	<input type="checkbox"/> 3	<input type="checkbox"/> 6	<input type="checkbox"/> 9
B3	<input type="checkbox"/> 0	<input type="checkbox"/> 3	<input type="checkbox"/> 6	<input type="checkbox"/> 9
B4	<input type="checkbox"/> 0	<input type="checkbox"/> 3	<input type="checkbox"/> 6	<input type="checkbox"/> 9
B5	<input type="checkbox"/> 0	<input type="checkbox"/> 3	<input type="checkbox"/> 6	<input type="checkbox"/> 9
B6	<input type="checkbox"/> 0	<input type="checkbox"/> 3	<input type="checkbox"/> 6	<input type="checkbox"/> 9
B7	<input type="checkbox"/> 0	<input type="checkbox"/> 3	<input type="checkbox"/> 6	<input type="checkbox"/> 9
B8	<input type="checkbox"/> 0	<input type="checkbox"/> 3	<input type="checkbox"/> 6	<input type="checkbox"/> 9
B9	<input type="checkbox"/> 0	<input type="checkbox"/> 3	<input type="checkbox"/> 6	<input type="checkbox"/> 9
B10	<input type="checkbox"/> 0	<input type="checkbox"/> 3	<input type="checkbox"/> 6	<input type="checkbox"/> 9
B11	<input type="checkbox"/> 0	<input type="checkbox"/> 3	<input type="checkbox"/> 6	<input type="checkbox"/> 9
B12	<input type="checkbox"/> 0	<input type="checkbox"/> 3	<input type="checkbox"/> 6	<input type="checkbox"/> 9
B13	<input type="checkbox"/> 0	<input type="checkbox"/> 3	<input type="checkbox"/> 6	<input type="checkbox"/> 9
B14	<input type="checkbox"/> 0	<input type="checkbox"/> 3	<input type="checkbox"/> 6	<input type="checkbox"/> 9
B15	<input type="checkbox"/> 0	<input type="checkbox"/> 3	<input type="checkbox"/> 6	<input type="checkbox"/> 9
B16	<input type="checkbox"/> 0	<input type="checkbox"/> 3	<input type="checkbox"/> 6	<input type="checkbox"/> 9
B17	<input type="checkbox"/> 0	<input type="checkbox"/> 3	<input type="checkbox"/> 6	<input type="checkbox"/> 9
B18	<input type="checkbox"/> 0	<input type="checkbox"/> 3	<input type="checkbox"/> 6	<input type="checkbox"/> 9
B19	<input type="checkbox"/> 0	<input type="checkbox"/> 3	<input type="checkbox"/> 6	<input type="checkbox"/> 9
B20	<input type="checkbox"/> 0	<input type="checkbox"/> 3	<input type="checkbox"/> 6	<input type="checkbox"/> 9
B21	<input type="checkbox"/> 0	<input type="checkbox"/> 3	<input type="checkbox"/> 6	<input type="checkbox"/> 9
B22	<input type="checkbox"/> 0	<input type="checkbox"/> 3	<input type="checkbox"/> 6	<input type="checkbox"/> 9
B23	<input type="checkbox"/> 0	<input type="checkbox"/> 3	<input type="checkbox"/> 6	<input type="checkbox"/> 9
B24	<input type="checkbox"/> 0	<input type="checkbox"/> 3	<input type="checkbox"/> 6	<input type="checkbox"/> 9

Total Score Section B



SECTION C: OTHER SYMPTOMS. While the symptoms in this section commonly occur in people with yeast connected illness they are also found in other individuals.

	None	Occ or mild	Frequent and/or Mod. severe	Severe and/or disabling
C1 Drowsiness	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
C2 Irritability or jitteriness	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
C3 Incoordination	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
C4 Inability to concentrate	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
C5 Frequent mood swings	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
C6 Headache	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
C7 Dizziness/loss of balance	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
C8 Pressure above ears/ feeling of head swelling	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
C9 Tendency to bruise easily	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
C10 Chronic rashes or itching	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
C11 Numbness, tingling	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
C12 Indigestion or heartburn	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
C13 Food sensitivity or intolerance	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
C14 Mucus in stools	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
C15 Rectal itching	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
C16 Dry mouth or throat	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
C17 Rash or blisters in mouth	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
C18 Bad breath	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
C19 Foot, body or hair odor not relieved by washing	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
C20 Nasal congestion or postnasal drip	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
C21 Nasal itching	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
C22 Sore throat	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
C23 Laryngitis, loss of voice	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
C24 Cough or recurrent bronchitis	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
C25 Pain or tightness in chest	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
C26 Wheezing or shortness of breath	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
C27 Urgency or urinary frequency	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
C28 Burning upon urination	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
C29 Spots in front of eyes or erratic vision	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
C30 Burning or tearing of eyes	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
C31 Recurrent infections or fluid in ears	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
C32 Ear pain or deafness	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Total Score Section C				

The Grand Total Score will help you and your physician decide if your health problems are yeast connected. Scores in women will run higher as 7 items in the questionnaire apply exclusively to women, while only 2 apply exclusively to men.

Total Score Section A

Total Score Section B

Total Score Section C

GRAND TOTAL SCORE

Yeast-connected health problems are	Men	Women
almost certainly present	>140	> 180
probably present	91 - 140	121 - 180
possibly present	41 - 90	61 - 120
unlikely	0 - 40	0 - 60



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Toxic, Ecological & Stress History:

Exposures at different periods of your life

1/24/2022 f_hx_tox_a.docx

Check ALL decades that apply

Name & Date:	No	Don't Know	Age 0-9	Age 10-19	Age 20-29	Age 30-49	Age 40-49	Age 50-59	Age 60-69	Age 70+	Your Notes more on back <input type="checkbox"/>	Please Leave Blank
1 Residence was built before 1970	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
2 Well water for your house	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
3 Wet or moldy basement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
4 New Construction < 5 yrs old	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
5 Work or live near a farm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
6 Work or live near factories	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
7 Work or live near nuclear reactor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
8 Work or live near landfill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
9 Solvent or pesticide exposure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
10 Hobbies with lead or other toxins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
11 Pets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
12 Mercury fillings placed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
13 Mercury fillings removed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
14 Root canals/teeth extracted (circle)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
15 Vaccines (even if routine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
16 Tuna or Swordfish > 2x/month	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
17 Mother smoked	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
18 Other house residents smoked	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
19 You smoked	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
20 Excess alcohol consumption	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
21 Adverse reaction-drugs (legal/street)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
22 IV antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
23 Oral or IV steroids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
24 Inhaled or topical steroids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
25 Birth Control Pill/Hormones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
26 Hospitalized and/or Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
27 Blood Transfusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
28 Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
29 Ear infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
30 Ear tubes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
31 Tonsils removed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
32 Sinus infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
33 Sinus surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
34 Appendectomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
35 Yeast infections/Thrush/Fungus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
36 Food poisoning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
37 Parasite Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
38 Herpes or Shingles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
39 Bladder Infections/UTI's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
40 Weight chnge >10# in < 12 mnths	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
41 Insomnia, Sleep Disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
42 Shift Work/All-Nighters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
43 Extreme Sport incl Run > 5 m/wk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
44 Concussion/Lost Consciousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
45 Sports Injury, even mild	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
46 Personal Injury: Car, Work, other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
47 Parents separated/divorced	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
48 You are separated/divorced	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
49 Serious family member illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
50 Abuse /Assault	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
51 Death of Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
52 Death of Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
53 Death of Sibling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
54 Death of Spouse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
55 Death of Other Family/Friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
56 Lost Job	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
57 Forced Sale/Eviction from Home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
58 Incarceration: you or family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
59 Other: (describe)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>



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Lab Set 1 & 2 Instruction Sheet for Patients

What lab work will I be getting done?

A sample of the lab order can be found here: [sample lab order](#) You can review this information with your insurance carrier ahead of time if you are concerned about what they will and will not cover.

Where can I have lab work done?

The choice between LabCorp, Quest or a Hospital lab is made by your insurance carrier and Primary Care Physician. Please contact your insurance carrier to clarify if you are uncertain.

Please note your first two sets of labs are very important. Therefore, we required that you use our local draw sites to improve the chance of a correct draw. Please ask our front desk for more information.

When must I have the lab work done?

Fasting a.m. labs must be drawn before 10 a.m. If you schedule an appointment, make it no later than 9:15. If you prefer to walk-in, do not arrive at the lab later than 9:00 am. The later you arrive, the greater the risk of your labs being drawn before 10 a.m. Do not go on a Saturday.

If desired, we will schedule an a.m. visit with the doctor on the same day after the draw.

How do I prepare for the lab work?

The night before:

Do not take any supplements, thyroid medications or potassium after 9 p.m.

You may take any other medications after 9 p.m.

You can always drink water or seltzer.

The morning of:

Do not take your supplements, thyroid medication or potassium.

You can take any other medications. Be sure to drink plenty of water (at least two cups).

If you are testing your morning urine, take a mid-stream sample with the first urination after 4am. See [clean catch](#) if you need more information.

Once the lab work is completed:

You may take your thyroid medications, potassium and morning supplements. Your night supplements can be skipped.

When will I be able to review the lab results?

Make an appointment between two to four weeks. Most labs also provide a patient portal that will allow you to check on your labs (but the doctor gets them before you). Portal instructions are here.

Patient Instructions:

before _____ am

Must draw locally

Fasting x 12 hrs

No Supps x 12 hrs

No T4 T3 K x12hrs

Non-fasting

any time

² m cycle day 18-21

³ well fed

⁴ no seafood x 3 days

⁵ off ppi 2 wks, fast 1 hr

⁶ no tourniquet, see dir

⁷ first urine of am

⁸ not affected by anti-TG Ab's

⁹ max \$40 total if "experimental"

Notes:

At your visit please note:

Date of Lab Visit (M-F, not Sat)

Arrival time: _____

Appointment time (optional): _____

Draw time: _____

Phlebotomist Name: _____