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

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Yeast Questionnaire

5/24/12-2 f_yeast_bf.doc

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 ☐ 0	Yes ☐ 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 ☐ 0	Yes ☐ 35	
A3	Have you taken a broad spectrum antibiotic drug *--even a single course?	No ☐ 0	Yes ☐ 8	
A4	Have you, at any time in your life, been bothered by persistent prostatitis, vaginitis or other problems affective your reproductive organs?	No ☐ 0	Yes ☐ 25	
A5	Have you been pregnant...	No ☐ 0	1 time ☐ 1	2 or more times ☐ 5
A6	Have you taken birth control pills...	No ☐ 0	for 6 months to 2 years ☐ 8	for more than 2 years ☐ 15
A7	Have you taken prednisone, Decadron or other cortisone-type drugs...	No ☐ 0	for 2 weeks or less? ☐ 6	for more than 2 weeks? ☐ 15
A8	Does exposure to perfumes, insecticides, auto exhaust, cleaners and other chemicals provoke any symptoms…	No ☐ 0	mild ☐ 5	moderate to severe ☐ 20
A9	Are your symptoms worse on damp, muggy days or in moldy places?	No ☐ 0	Yes ☐ 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 ☐ 0	Mild to moderate ☐ 10	Severe or persistent? ☐ 20
A11	Do you crave sugar?	No ☐ 0	Yes ☐ 10	
A12	Do you crave breads?	No ☐ 0	Yes ☐ 10	
A13	Do you crave alcoholic beverages?	No ☐ 0	Yes ☐ 10	
A14	Does tobacco smoke really bother you?	No ☐ 0	Yes ☐ 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	Fatigue or lethargy	☐ 0	☐ 3	☐ 6	☐ 9
B2	Feeling of being "drained"	☐ 0	☐ 3	☐ 6	☐ 9
B3	Poor memory	☐ 0	☐ 3	☐ 6	☐ 9
B4	Feeling "spacey" or "unreal"	☐ 0	☐ 3	☐ 6	☐ 9
B5	Depression	☐ 0	☐ 3	☐ 6	☐ 9
B6	Inability to make decisions	☐ 0	☐ 3	☐ 6	☐ 9
B7	Numbness, burning or tingling	☐ 0	☐ 3	☐ 6	☐ 9
B8	Muscle aches or weakness	☐ 0	☐ 3	☐ 6	☐ 9
B9	Pain and/or swelling in joints	☐ 0	☐ 3	☐ 6	☐ 9
B10	Abdominal pain	☐ 0	☐ 3	☐ 6	☐ 9
B11	Constipation	☐ 0	☐ 3	☐ 6	☐ 9
B12	Diarrhea	☐ 0	☐ 3	☐ 6	☐ 9
B13	Bloating, belching or intestinal gas	☐ 0	☐ 3	☐ 6	☐ 9
B14	Troublesome vaginal burning, itching discharge	☐ 0	☐ 3	☐ 6	☐ 9
B15	Persistent vaginal burning or itching	☐ 0	☐ 3	☐ 6	☐ 9
B16	Prostatitis	☐ 0	☐ 3	☐ 6	☐ 9
B17	Impotence	☐ 0	☐ 3	☐ 6	☐ 9
B18	Loss of sexual desire or feeling	☐ 0	☐ 3	☐ 6	☐ 9
B19	Endometriosis or infertility	☐ 0	☐ 3	☐ 6	☐ 9
B20	Cramps and/or other menstrual irregularities	☐ 0	☐ 3	☐ 6	☐ 9
B21	Premenstrual tension	☐ 0	☐ 3	☐ 6	☐ 9
B22	Attacks of anxiety or crying	☐ 0	☐ 3	☐ 6	☐ 9
B23	Cold hands or feet and/or chilliness	☐ 0	☐ 3	☐ 6	☐ 9
B24	Shaking or irritable when hungry	☐ 0	☐ 3	☐ 6	☐ 9

Total Score Section B

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5/24/12-2 f_yeast_bf.doc

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	☐ 0	☐ 1	☐ 2	☐ 3
C2	Irritability or jitteriness	☐ 0	☐ 1	☐ 2	☐ 3
C3	Incoordination	☐ 0	☐ 1	☐ 2	☐ 3
C4	Inability to concentrate	☐ 0	☐ 1	☐ 2	☐ 3
C5	Frequent mood swings	☐ 0	☐ 1	☐ 2	☐ 3
C6	Headache	☐ 0	☐ 1	☐ 2	☐ 3
C7	Dizziness/loss of balance	☐ 0	☐ 1	☐ 2	☐ 3
C8	Pressure above ears/ feeling of head swelling	☐ 0	☐ 1	☐ 2	☐ 3
C9	Tendency to bruise easily	☐ 0	☐ 1	☐ 2	☐ 3
C10	Chronic rashes or itching	☐ 0	☐ 1	☐ 2	☐ 3
C11	Numbness, tingling	☐ 0	☐ 1	☐ 2	☐ 3
C12	Indigestion or heartburn	☐ 0	☐ 1	☐ 2	☐ 3
C13	Food sensitivity or intolerance	☐ 0	☐ 1	☐ 2	☐ 3
C14	Mucus in stools	☐ 0	☐ 1	☐ 2	☐ 3
C15	Rectal itching	☐ 0	☐ 1	☐ 2	☐ 3
C16	Dry mouth or throat	☐ 0	☐ 1	☐ 2	☐ 3
C17	Rash or blisters in mouth	☐ 0	☐ 1	☐ 2	☐ 3
C18	Bad breath	☐ 0	☐ 1	☐ 2	☐ 3
C19	Foot, body or hair odor not relieved by washing	☐ 0	☐ 1	☐ 2	☐ 3
C20	Nasal congestion or postnasal drip	☐ 0	☐ 1	☐ 2	☐ 3
C21	Nasal itching	☐ 0	☐ 1	☐ 2	☐ 3
C22	Sore throat	☐ 0	☐ 1	☐ 2	☐ 3
C23	Laryngitis, loss of voice	☐ 0	☐ 1	☐ 2	☐ 3
C24	Cough or recurrent bronchitis	☐ 0	☐ 1	☐ 2	☐ 3
C25	Pain or tightness in chest	☐ 0	☐ 1	☐ 2	☐ 3
C26	Wheezing or shortness of breath	☐ 0	☐ 1	☐ 2	☐ 3
C27	Urgency or urinary frequency	☐ 0	☐ 1	☐ 2	☐ 3
C28	Burning upon urination	☐ 0	☐ 1	☐ 2	☐ 3
C29	Spots in front of eyes or erratic vision	☐ 0	☐ 1	☐ 2	☐ 3
C30	Burning or tearing of eyes	☐ 0	☐ 1	☐ 2	☐ 3
C31	Recurrent infections or fluid in ears	☐ 0	☐ 1	☐ 2	☐ 3
C32	Ear pain or deafness	☐ 0	☐ 1	☐ 2	☐ 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

f_hx_tox_a_2019_09_06.docx

Check ALL decades that apply

	Name & Date:	Know	Age 0-10	Age 11-19	Age 20-29	Age 30-39	Age 40-49	Age 50-59	Age 60+	**Last 2 years**	Your Notes more on back ☐	**Please Leave Blank**
1	Residence was built before 1970	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2	Well water for your house	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3	Wet or moldy basement	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4	New Construction < 5 yrs old	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5	Work or live near a **farm**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6	Work or live near **factories**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
7	Work or live near **nuclear reactor**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
8	Work or live near **landfill**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
9	Solvent or pesticide exposure	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
10	Hobbies with lead or other toxins	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
11	Pets	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
12	Mercury fillings placed	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
13	Mercury fillings removed	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
14	Root canals/teeth extracted (circle)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
15	Vaccines (even if routine)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
16	Tuna or Swordfish > 2x/month	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
17	Mother smoked	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18	Other house residents smoked	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19	You smoked	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20	Excess alcohol consumption	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21	Adverse reaction-drugs (legal/street)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22	IV antibiotics	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
23	Oral or IV steroids	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
24	Inhaled or topical steroids	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
25	Birth Control Pill/Hormones	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
26	Hospitalized and/or Surgery	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
27	Blood Transfusions	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
28	Pneumonia	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
29	Ear infections	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
30	Ear tubes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
31	Tonsils removed	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
32	Sinus infections	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
33	Sinus surgery	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
34	Appendectomy	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
35	Yeast infections/Thrush/Fungus	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
36	Food poisoning	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
37	Parasite Infection	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
38	Herpes or Shingles	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
39	Bladder Infections/UTI's	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
40	Weight chnge >10# in < 12 mnths	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
41	Insomnia, Sleep Disturbance	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
42	Shift Work/All-Nighters	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
43	Extreme Sport incl Run > 5 m/wk	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
44	Concussion/Lost Consciousness	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
45	Sports Injury, even mild	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
46	Personal Injury: Car, Work, other	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
47	Parents separated/divorced	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
48	You are separated/divorced	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
49	Serious family member illness	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
50	Abuse /Assault	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
51	Death of Father	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
52	Death of Mother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
53	Death of Sibling	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
54	Death of Spouse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
55	Death of Other Family/Friend	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
56	Lost Job	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
57	Forced Sale/Eviction from Home	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
58	Incarceration: you or family	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
59	Other: (describe)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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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 edications. 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: _____