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Nutritional Assessment Questionnaire

pt.: _____ DOB: _____ M F Date: _____

Please list your four major health concerns in order of importance:

1. _____ 3. _____
2. _____ 4. _____

PART I Read the following questions and circle the number that applies:

KEY: 0 = Do not consume or use 2 = Consume or use weekly
1 = Consume or use 2 to 3 times monthly 3 = Consume or use daily

DIET

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|---|----------------------------------|---|
| 1. 0 1 2 3 Alcohol | 7. 0 1 2 3 Cigars/pipes | 14. 0 1 Radiation exposure (0=no, 1=yes) |
| 2. 0 1 2 3 Artificial sweeteners | 8. 0 1 2 3 Caffeinated beverages | 15. 0 1 2 3 Refined flour/baked goods |
| 3. 0 1 2 3 Candy, desserts, refined sugar | 9. 0 1 2 3 Fast foods | 16. 0 1 2 3 Vitamins and minerals |
| 4. 0 1 2 3 Carbonated beverages | 10. 0 1 2 3 Fried foods | 17. 0 1 2 3 Water, distilled |
| 5. 0 1 2 3 Chewing tobacco | 11. 0 1 2 3 Luncheon meats | 18. 0 1 2 3 Water, tap |
| 6. 0 1 2 3 Cigarettes | 12. 0 1 2 3 Margarine | 19. 0 1 2 3 Water, well |
| | 13. 0 1 2 3 Milk products | 20. 0 1 2 3 Diet often for weight control |

LIFESTYLE

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21. 0 1 2 3 Exercise per week (0 = 2 or more times a week, 1=1 time a week, 2 = 1 or 2 times a month, 3 = never, less than once a month)
22. 0 1 2 3 Changed jobs (0 = over 12 months ago, 1 = within last 12 months, 2 = within last 6 months, 3 = within last 2 months)
23. 0 1 2 3 Divorced (0 = never, over 2 years ago, 1 = within last 2 years, 2 = within last year, 3 = within last 6 months)
24. 0 1 2 3 Work over 60 hours/week (0 = never, 1 = occasionally, 2 = usually, 3 = always)

MEDICATIONS Indicate any medications you're currently taking or have taken in the last month (0=no, 1=yes):

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|--|---|
| 25. 0 1 Antacids | 39. 0 1 Diuretics |
| 26. 0 1 Antianxiety medications | 40. 0 1 Estrogen or progesterone (pharmaceutical, prescription) |
| 27. 0 1 Antibiotics | 41. 0 1 Estrogen or progesterone (natural) |
| 28. 0 1 Anticonvulsants | 42. 0 1 Heart medications |
| 29. 0 1 Antidepressants | 43. 0 1 High blood pressure medications |
| 30. 0 1 Antifungals | 44. 0 1 Laxatives |
| 31. 0 1 Aspirin/ibuprofen | 45. 0 1 Recreational drugs |
| 32. 0 1 Asthma inhalers | 46. 0 1 Relaxants/Sleeping pills |
| 33. 0 1 Beta blockers | 47. 0 1 Testosterone (natural or prescription) |
| 34. 0 1 Birth control pills/implant contraceptives | 48. 0 1 Thyroid medication |
| 35. 0 1 Chemotherapy | 49. 0 1 Acetaminophen (Tylenol) |
| 36. 0 1 Cholesterol lowering medications | 50. 0 1 Ulcer medications |
| 37. 0 1 Cortisone/steroids | 51. 0 1 Sildenafil citrate (Viagra) |
| 38. 0 1 Diabetic medications/insulin | |

PART II (See key at bottom of page)

Section 1

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|---|--|
| 52. 0 1 2 3 Belching or gas within one hour after eating | 61. 0 1 2 3 Feel like skipping breakfast |
| 53. 0 1 2 3 Heartburn or acid reflux | 62. 0 1 2 3 Feel better if you don't eat |
| 54. 0 1 2 3 Bloating within one hour after eating | 63. 0 1 2 3 Sleepy after meals |
| 55. 0 1 Vegan diet (no dairy, meat, fish or eggs) (0=no, 1=yes) | 64. 0 1 2 3 Fingernails chip, peel or break easily |
| 56. 0 1 2 3 Bad breath (halitosis) | 65. 0 1 2 3 Anemia unresponsive to iron |
| 57. 0 1 2 3 Loss of taste for meat | 66. 0 1 2 3 Stomach pains or cramps |
| 58. 0 1 2 3 Sweat has a strong odor | 67. 0 1 2 3 Diarrhea, chronic |
| 59. 0 1 2 3 Stomach upset by taking vitamins | 68. 0 1 2 3 Diarrhea shortly after meals |
| 60. 0 1 2 3 Sense of excess fullness after meals | 69. 0 1 2 3 Black or tarry colored stools |
| | 70. 0 1 2 3 Undigested food in stool |

KEY: 0=No, symptom does not occur 2=Moderate symptom, occurs occasionally (weekly)
1=Yes, minor or mild symptom, rarely occurs (monthly) 3=Severe symptom, occurs frequently (daily)

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Nutritional Assessment Questionnaire

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Section 2

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|-------------|--|-------------|--|
| 71. 0 1 2 3 | Pain between shoulder blades | 85. 0 1 | Easily hung over if you were to drink wine (0=no, 1=yes) |
| 72. 0 1 2 3 | Stomach upset by greasy foods | 86. 0 1 2 3 | Alcohol per week (0=<3, 1=<7, 2=<14, 3=>14) |
| 73. 0 1 2 3 | Greasy or shiny stools | 87. 0 1 | Recovering alcoholic (0=no, 1=yes) |
| 74. 0 1 2 3 | Nausea | 88. 0 1 | History of drug or alcohol abuse (0=no, 1=yes) |
| 75. 0 1 2 3 | Sea, car, airplane or motion sickness | 89. 0 1 | History of hepatitis (0=no, 1=yes) |
| 76. 0 1 | History of morning sickness (0 = no, 1 = yes) | 90. 0 1 | Long term use of prescription/recreational drugs (0=no, 1=yes) |
| 77. 0 1 2 3 | Light or clay colored stools | 91. 0 1 2 3 | Sensitive to chemicals (perfume, cleaning agents, etc) |
| 78. 0 1 2 3 | Dry skin, itchy feet or skin peels on feet | 92. 0 1 2 3 | Sensitive to tobacco smoke |
| 79. 0 1 2 3 | Headache over eyes | 93. 0 1 2 3 | Exposure to diesel fumes |
| 80. 0 1 2 3 | Gallbladder attacks (0=never, 1=years ago, 2=within last year, 3=within past 3 months) | 94. 0 1 2 3 | Pain under right side of rib cage |
| 81. 0 1 | Gallbladder removed (0=no, 1 =yes) | 95. 0 1 2 3 | Hemorrhoids or varicose veins |
| 82. 0 1 2 3 | Bitter taste in mouth, especially after meals | 96. 0 1 2 3 | Nutrasweet (aspartame) consumption |
| 83. 0 1 | Become sick if you were to drink wine (0=no, 1=yes) | 97. 0 1 2 3 | Sensitive to Nutrasweet (aspartame) |
| 84. 0 1 | Easily intoxicated if you were to drink wine (0=no, 1=yes) | 98. 0 1 2 3 | Chronic fatigue or Fibromyalgia |

Section 3

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|--------------|--|--------------|--|
| 99. 0 1 2 3 | Food allergies | 108. 0 1 2 3 | Crohn's disease (0 =no, 1 =yes in the past, 2=currenty mild condition, 3=severe) |
| 100. 0 1 2 3 | Abdominal bloating 1 to 2 hours after eating | 109. 0 1 2 3 | Wheat or grain sensitivity |
| 101. 0 1 | Specific foods make you tired or bloated (0=no, 1=yes) | 110. 0 1 2 3 | Dairy sensitivity |
| 102. 0 1 2 3 | Pulse speeds after eating | 111. 0 1 | Are there foods you could not give up (0=no, 1=yes) |
| 103. 0 1 2 3 | Airborne allergies | 112. 0 1 2 3 | Asthma, sinus infections, stuffy nose |
| 104. 0 1 2 3 | Experience hives | 113. 0 1 2 3 | Bizarre vivid dreams, nightmares |
| 105. 0 1 2 3 | Sinus congestion, "stuffy head" | 114. 0 1 2 3 | Use over-the-counter pain medications |
| 106. 0 1 2 3 | Crave bread or noodles | 115. 0 1 2 3 | Feel spacey or unreal |
| 107. 0 1 2 3 | Alternating constipation and diarrhea | | |

Section 4

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|--------------|---|--------------|--|
| 116. 0 1 2 3 | Anus itches | 126. 0 1 2 3 | Stools have comers or edges, are flat or ribbon shaped |
| 117. 0 1 2 3 | Coated tongue | 127. 0 1 2 3 | Stools are not well formed (loose) |
| 118. 0 1 2 3 | Feel worse in moldy or musty place | 128. 0 1 2 3 | Irritable bowel or mucus colitis |
| 119. 0 1 2 3 | Taken antibiotic for a total accumulated time of (0=never, 1= <1 month, 2= <3 months, 3= >3 months) | 129. 0 1 2 3 | Blood in stool |
| 120. 0 1 2 3 | Fungus or yeast infections | 130. 0 1 2 3 | Mucus in stool |
| 121. 0 1 2 3 | Ring worm, "jock itch", "athletes foot", nail fungus | 131. 0 1 2 3 | Excessive foul smelling lower bowel gas |
| 122. 0 1 2 3 | Yeast symptoms increase with sugar, starch or alcohol | 132. 0 1 2 3 | Bad breath or strong body odors |
| 123. 0 1 2 3 | Stools hard or difficult to pass | 133. 0 1 2 3 | Painful to press along outer sides of thighs (Iliotibial Band) |
| 124. 0 1 | History of parasites (0=no, 1=yes) | 134. 0 1 2 3 | Cramping in lower abdominal region |
| 125. 0 1 2 3 | Less than one bowel movement per day | 135. 0 1 2 3 | Dark circles under eyes |

Section 5

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|--------------|--|--------------|-------------------------------------|
| 136. 0 1 | History of carpal tunnel syndrome (0=no, 1=yes) | 150. 0 1 | History of bone spurs (0=no, 1=yes) |
| 137. 0 1 | History of lower right abdominal pains or ileocecal valve problems (0=no, 1=yes) | 151. 0 1 2 3 | Morning stiffness |
| 138. 0 1 | History of stress fracture (0=no, 1=yes) | 152. 0 1 2 3 | Nausea with vomiting |
| 139. 0 1 2 3 | Bone loss (reduced density on bone scan) | 153. 0 1 2 3 | Crave chocolate |
| 140. 0 1 | Are you shorter than you used to be? (0=no, 1=yes) | 154. 0 1 2 3 | Feet have a strong odor |
| 141. 0 1 2 3 | Calf, foot or toe cramps at rest | 155. 0 1 2 3 | History of anemia |
| 142. 0 1 2 3 | Cold sores, fever blisters or herpes lesions | 156. 0 1 2 3 | Whites of eyes (sclera) blue tinted |
| 143. 0 1 2 3 | Frequent fevers | 157. 0 1 2 3 | Hoarseness |
| 144. 0 1 2 3 | Frequent skin rashes and/or hives | 158. 0 1 2 3 | Difficulty swallowing |
| 145. 0 1 | Herniated disc (0=no, 1=yes) | 159. 0 1 2 3 | Lump in throat |
| 146. 0 1 2 3 | Excessively flexible joints, "double jointed" | 160. 0 1 2 3 | Dry mouth, eyes and/or nose |
| 147. 0 1 2 3 | Joints pop or click | 161. 0 1 2 3 | Gag easily |
| 148. 0 1 2 3 | Pain or swelling in joints | 162. 0 1 2 3 | White spots on fingernails |
| 149. 0 1 2 3 | Bursitis or tendonitis | 163. 0 1 2 3 | Cuts heal slowly and/or scar easily |
| | | 164. 0 1 2 3 | Decreased sense of taste or smell |

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Section 6

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|------|---------|---|------|---------|--|
| 165. | 0 1 | Experience pain relief with aspirin (0=no, 1=yes) | 169. | 0 1 2 3 | Headaches when out in the hot sun |
| 166. | 0 1 2 3 | Crave fatty or greasy foods | 170. | 0 1 2 3 | Sunburn easily or suffer sun poisoning |
| 167. | 0 1 2 3 | Low-or reduced-fat diet (0=never, 1=years ago, 2=within past year, 3=currently) | 171. | 0 1 2 3 | Muscles easily fatigued |
| 168. | 0 1 2 3 | Tension headaches at base of skull | 172. | 0 1 2 3 | Dry flaky skin or dandruff |

Section 7

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|------|---------|--|------|---------|--|
| 173. | 0 1 2 3 | Awaken a few hours after falling asleep, hard to get back to sleep | 180. | 0 1 2 3 | Headache if meals are skipped or delayed |
| 174. | 0 1 2 3 | Crave sweets | 181. | 0 1 2 3 | Irritable before meals |
| 175. | 0 1 2 3 | Binge or uncontrolled eating | 182. | 0 1 2 3 | Shaky if meals delayed |
| 176. | 0 1 2 3 | Excessive appetite | 183. | 0 1 2 3 | Family members with diabetes (0=none, 1=1 or 2, 2=3 or 4, 3=morethan4) |
| 177. | 0 1 2 3 | Crave coffee or sugar in the afternoon | 184. | 0 1 2 3 | Frequent thirst |
| 178. | 0 1 2 3 | Sleepy in afternoon | 185. | 0 1 2 3 | Frequent urination |
| 179. | 0 1 2 3 | Fatigue that is relieved by eating | | | |

Section 8

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|------|---------|---|------|---------|--|
| 186. | 0 1 2 3 | Muscles become easily fatigued | 200. | 0 1 2 3 | Can hear heart beat on pillow at night |
| 187. | 0 1 2 3 | Feel exhausted or sore after moderate exercise | 201. | 0 1 2 3 | Whole body or limb jerk as falling asleep |
| 188. | 0 1 2 3 | Vulnerable to insect bites | 202. | 0 1 2 3 | Night sweats |
| 189. | 0 1 2 3 | Loss of muscle tone, heaviness in arms/legs | 203. | 0 1 2 3 | Restless leg syndrome |
| 190. | 0 1 2 3 | Enlarged heart or congestive heart failure | 204. | 0 1 2 3 | Cracks at corner of mouth (Cheilosis) |
| 191. | 0 1 2 3 | Pulse below 65 per minute (0=no, 1=yes) | 205. | 0 1 2 3 | Fragile skin, easily chaffed, as in shaving |
| 192. | 0 1 2 3 | ringing in the ears (Tinnitus) | 206. | 0 1 2 3 | Polyps or warts |
| 193. | 0 1 2 3 | Numbness, tingling or itching in hands and feet | 207. | 0 1 2 3 | MSG sensitivity |
| 194. | 0 1 2 3 | Depressed | 208. | 0 1 2 3 | Wake up without remembering dreams |
| 195. | 0 1 2 3 | Fear of impending doom | 209. | 0 1 2 3 | Small bumps on back of arms |
| 196. | 0 1 2 3 | Worrier, apprehensive, anxious | 210. | 0 1 2 3 | Strong light at night irritates eyes |
| 197. | 0 1 2 3 | Nervous or agitated | 211. | 0 1 2 3 | Nose bleeds and/or tend to bruise easily |
| 198. | 0 1 2 3 | Feelings of insecurity | 212. | 0 1 2 3 | Bleeding gums especially when brushing teeth |
| 199. | 0 1 2 3 | Heart races | | | |

Section 9

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|------|---------|--|------|---------|--|
| 213. | 0 1 2 3 | Tend to be a "night person" | 226. | 0 1 2 3 | Arthritic tendencies |
| 214. | 0 1 2 3 | Difficulty falling asleep | 227. | 0 1 2 3 | Crave salty foods |
| 215. | 0 1 2 3 | Slow starter in the morning | 228. | 0 1 2 3 | Salt foods before tasting |
| 216. | 0 1 2 3 | Tend to be keyed up, trouble calming down | 229. | 0 1 2 3 | Perspire easily |
| 217. | 0 1 2 3 | Blood pressure above 120/80 | 230. | 0 1 2 3 | Chronic fatigue, or get drowsy often |
| 218. | 0 1 2 3 | Headache after exercising | 231. | 0 1 2 3 | Afternoon yawning |
| 219. | 0 1 2 3 | Feeling wired or jittery after drinking coffee | 232. | 0 1 2 3 | Afternoon headache |
| 220. | 0 1 2 3 | Clench or grind teeth | 233. | 0 1 2 3 | Asthma, wheezing or difficulty breathing |
| 221. | 0 1 2 3 | Calm on the outside, troubled on the inside | 234. | 0 1 2 3 | Pain on the medial or inner side of the knee |
| 222. | 0 1 2 3 | Chronic low back pain, worse with fatigue | 235. | 0 1 2 3 | Tendency to sprain ankles or "shin splints" |
| 223. | 0 1 2 3 | Become dizzy when standing up suddenly | 236. | 0 1 2 3 | Tendency to need sunglasses |
| 224. | 0 1 2 3 | Difficulty maintaining manipulative correction | 237. | 0 1 2 3 | Weakness, dizziness |

Section 10

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|------|---------|---|------|---------|---|
| 239. | 0 1 | Height over 6'6" (0=no, 1=yes) | 245. | 0 1 | Height under 4' 10" (0=no, 1=yes) |
| 240. | 0 1 | Early sexual development (before age 10) (0=no, 1=yes) | 246. | 0 1 2 3 | Decreased libido |
| 241. | 0 1 2 3 | Increased libido | 247. | 0 1 2 3 | Excessive thirst |
| 242. | 0 1 2 3 | Splitting type headache | 248. | 0 1 2 3 | Weight gain around hips or waist |
| 243. | 0 1 2 3 | Memory failing | 249. | 0 1 2 3 | Menstrual disorders |
| 244. | 0 1 | Tolerate sugar, feel fine when eating sugar (0=no, 1=yes) | 250. | 0 1 | Delayed sexual development (after age 13) (0=no, 1=yes) |
| | | | 251. | 0 1 2 3 | Tendency to ulcers or colitis |

KEY: 0=No, symptom does not occur
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Section 11

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|------|---------|---|------|---------|---|
| 252. | 0 1 2 3 | Sensitive/allergic to iodine | 260. | 0 1 2 3 | Mentally sluggish, reduced initiative |
| 253. | 0 1 2 3 | Difficulty gaining weight, even with large appetite | 261. | 0 1 2 3 | Easily fatigued, sleepy during the day |
| 254. | 0 1 2 3 | Nervous, emotional, can't work under pressure | 262. | 0 1 2 3 | Sensitive to cold, poor circulation (cold hands and feet) |
| 255. | 0 1 2 3 | Inward trembling | 263. | 0 1 2 3 | Constipation, chronic |
| 256. | 0 1 2 3 | Flush easily | 264. | 0 1 2 3 | Excessive hair loss and/or coarse hair |
| 257. | 0 1 2 3 | Fast pulse at rest | 265. | 0 1 2 3 | Morning headaches, wear off during the day |
| 258. | 0 1 2 3 | Intolerance to high temperatures | 266. | 0 1 2 3 | Loss of lateral 1/3 of eyebrow |
| 259. | 0 1 2 3 | Difficulty losing weight | 267. | 0 1 2 3 | Seasonal sadness |

Section 12 - Men Only

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|------|---------|--|------|---------|---|
| 268. | 0 1 2 3 | Prostate problems | 272. | 0 1 2 3 | Waking to urinate at night |
| 269. | 0 1 2 3 | Difficulty with urination, dribbling | 273. | 0 1 2 3 | Interruption of stream during urination |
| 270. | 0 1 2 3 | Difficult to start and stop urine stream | 274. | 0 1 2 3 | Pain on inside of legs or heels |
| 271. | 0 1 2 3 | Pain or burning with urination | 275. | 0 1 2 3 | Feeling of incomplete bowel evacuation |
| 276. | 0 1 2 3 | Decreased sexual function | | | |

Section 13 - Women Only

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|------|---------|---|------|---------|--|
| 277. | 0 1 2 3 | Depression during periods | 287. | 0 1 2 3 | Breast fibroids, benign masses |
| 278. | 0 1 2 3 | Mood swings associated with periods (PMS) | 288. | 0 1 2 3 | Painful intercourse (dysparenia) |
| 279. | 0 1 2 3 | Crave chocolate around periods | 289. | 0 1 2 3 | Vaginal discharge |
| 280. | 0 1 2 3 | Breast tenderness associated with cycle | 290. | 0 1 2 3 | Vaginal dryness |
| 281. | 0 1 2 3 | Excessive menstrual flow | 291. | 0 1 2 3 | Vaginal itchiness |
| 282. | 0 1 2 3 | Scanty blood flow during periods | 292. | 0 1 2 3 | Gain weight around hips, thighs and buttocks |
| 283. | 0 1 2 3 | Occasional skipped periods | 293. | 0 1 2 3 | Excess facial or body hair |
| 284. | 0 1 2 3 | Variations in menstrual cycles | 294. | 0 1 2 3 | Hot flashes |
| 285. | 0 1 2 3 | Endometriosis | 295. | 0 1 2 3 | Night sweats (in menopausal females) |
| 286. | 0 1 2 3 | Uterine fibroids | 296. | 0 1 2 3 | Thinning skin |

Section 14

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|------|---------|--|------|---------|--|
| 297. | 0 1 2 3 | Aware of heavy and/or irregular breathing | 302. | 0 1 2 3 | Ankles swell, especially at end of day |
| 298. | 0 1 2 3 | Discomfort at high altitudes | 303. | 0 1 2 3 | Cough at night |
| 299. | 0 1 2 3 | "Air hunger" or sigh frequently | 304. | 0 1 2 3 | Blush or face turns red for no reason |
| 300. | 0 1 2 3 | Compelled to open windows in a closed room | 305. | 0 1 2 3 | Dull pain or tightness in chest and/or radiate into right arm, worse with exertion |
| 301. | 0 1 2 3 | Shortness of breath with moderate exertion | | | |
| 306. | 0 1 2 3 | Muscle cramps with exertion | | | |

Section 15

13

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|------|---------|--|------|---------|----------------------------------|
| 307. | 0 1 2 3 | Pain in mid-back region | 310. | 0 1 2 3 | Cloudy, bloody or darkened urine |
| 308. | 0 1 2 3 | Puffy around the eyes, dark circles under eyes | 311. | 0 1 2 3 | Urine has a strong odor |
| 309. | 0 1 | History of kidney stones (0=no, 1=yes) | | | |

Section 16

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|------|---------|--|------|---------|--|
| 312. | 0 1 2 3 | Runny or drippy nose | 317. | 0 1 2 3 | Never get sick (0 = sick only 1 or 2 times in last 2 years, 1 = not sick in last 2 years, 2 = not sick in last 4 years, 3 = not sick in last 7 years) |
| 313. | 0 1 2 3 | Catch colds at the beginning of winter | 318. | 0 1 2 3 | Acne (adult) |
| 314. | 0 1 2 3 | Mucus producing cough | 319. | 0 1 2 3 | Itchy skin (Dermatitis) |
| 315. | 0 1 2 3 | Frequent colds or flu (0=1 or less per year, 1=2 to 3 times per year, 2=4 to 5 times per year, 3=6 or more times per year) | 320. | 0 1 2 3 | Cysts, boils, rashes |
| 316. | 0 1 2 3 | Other infections (sinus, ear, lung, skin, bladder, kidney, etc) (0=1 or less per year, 1=2 to 3 times per year, 2=4 to 5 times per year, 3=6 or more times per year) | 321. | 0 1 2 3 | History of Epstein Bar, Mono, Herpes, Shingles, Chronic Fatigue Syndrome, Hepatitis or other chronic viral condition (0 = no, 1 = yes in the past, 2 = currently mild condition, 3 = severe) |

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