Screening Questionnaire

Patient Name _____ Date _____

1. Have you ever had exposure to Mold? ◯Y or N◯
2. Have you ever had a diagnosis of H. Pylori? ◯Y or N◯
3. Have you ever been diagnosed or tested for Celiac Disease or Non-Celiac Gluten Sensitivity? ◯Y or N◯
4. Have you had Endoscopic or Colonoscopic evaluation for any gut disorder? ◯Y or N◯
5. Have you ever had a history of rectal itching? ◯Y or N◯
6. Have you ever had a history of ear itching? ◯Y or N◯
7. Have you ever had exposure to chemicals or toxins due to work or Environmental hazardous exposure? ◯Y or N◯
8. Have you ever traveled to underserved areas or countries? ◯Y or N◯
   If so where _____
9. Do you crave carbs and/or sweets? ◯Y or N◯
10. Have you ever had a tick bite? ◯Y or N◯
11. Have you ever had a history on mononucleosis? ◯Y or N◯
12. Have you had history of dental work, implants or amalgams? ◯Y or N◯
13. Have you had a history of gastroenteritis? ◯Y or N◯
14. Have you had a history of antibiotic(s) use? ◯Y or N◯
    If so name of antibiotic(s)

    _____
15. Have you had a history of recurrent yeast infections? ◯Y or N◯
16. Do you think you sweat enough? ◯Y of N◯
17. Do you hike often? ◯Y or N◯
18. How would you grade your sleep in 1-10? _____
19. How would you grade your eating habits in 1-10? _____
20. How is your stress level? Mild, Moderate or High
21. How often do you exercise in a week? _____
22. How is your relationship with Family and Friends? _____
23. What are your top 3 health concerns that you would like the Doctor to address today?

    _____

    _____

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