IMMUNE DYSFUNCTION QUESTIONNAIRE

This symptom checklist is not sufficient to diagnose an immune dysfunction unless other disorders have been ruled out by appropriate assessment.

Following is a list of symptoms. In the blank to the left of each symptom, rate the severity of the symptom from 0 to 10, with 10 being most severe. To the right of the symptom, list how long you have noticed the symptom.

SEVERITY 0-10	SYMPTOM	When did you first notice this **symptom?**
_____	Fatigue – usually made worse by physical exercise	_____
_____	Attention deficit disorder (ADD/ADHD)……	_____
_____	Memory disturbance……...	_____
_____	Confused easily or change in ability to learn……..	_____
_____	Spatial disorientation……..	_____
_____	Frequently saying the wrong word……	_____
_____	Depression……..	_____
_____	Anxiety……	_____
_____	Personality changes……	_____
_____	Mood swings……..	_____
_____	Sleep disturbance……	_____
_____	Frequent unusual nightmares……..	_____
_____	Headaches……	_____
_____	Changes in visual acuity…….	_____
_____	Blurred Vision or Visual Episodes (explain)……..	_____
_____	Seizures……..	_____
_____	Numb or tingling feelings……..	_____
_____	Disequilibria……..	_____
_____	Lightheadedness – feeling “spaced out”……	_____
_____	Difficulty moving your tongue to speak……	_____
_____	Ringing in ears……	_____
_____	Paralysis…….	_____
_____	Severe muscular weakness…….	_____
_____	Blackouts……	_____
_____	Intolerance of bright lights…….	_____
_____	Intolerance of alcohol……	_____
_____	Decreased libido…….	_____
_____	Muscle and joint aches……	_____
_____	Decreased mobility……	_____
_____	Sore(s) that will not heal…….	_____
_____	Red slapped cheek look……..	_____
_____	Bruises easily……	_____

Name: Date

_____	Twitching muscles…… Where?…….	_____
_____	Tremors……..	_____
_____	Recurrent flu-like illnesses (often with chronic sore throat)…….	_____
_____	Hoarseness or vocal tone changes / irregularities	_____
_____	Painful lymph nodes…….. Where?	_____
_____	Severe nasal and other allergies…….	_____
_____	Abnormal weight gain and/or loss…….	_____
_____	Abdominal pain, diarrhea, nausea, intestinal gas or "irritable bowel syndrome"…….. ……	_____
_____	Low grade fevers or feeling hot often……	_____
_____	Night sweats……..	_____
_____	Heart palpitations or other rhythm disturbances…	_____
_____	Rash or Herpes Simples or Shingles…….	_____
_____	Uncomfortable urination……	_____
_____	Frequent urination……	_____
_____	Rashes……	_____
_____	Hair loss……	_____
_____	Impotence…….	_____
_____	Chest pain…….	_____
_____	Dry eyes and mouth…….	_____
_____	Cough……	_____
_____	Mitral valve prolapse……	_____
_____	Frequent canker sores……	_____
_____	Cold hands and feet……	_____
_____	Carpal tunnel syndrome……	_____
_____	Lower back pain……..	_____
_____	Thyroid inflammation……	_____
_____	Cancer……	_____
_____	Periodontal (gum) disease…….	_____
_____	Endometriosis……	_____
_____	Easily getting out of breath……	_____
_____	Symptoms worsened by extremes in temperature	_____
_____	Multiple sensitivities to medicine, food and other substances……	_____
_____	Nail Fungus…….	_____
_____	Nose Bleeds…….	_____

OTHER SYMPTOMS (if you need additional space, please add another page)

_____ _____ _____

Name: Date

PERSONAL AND FAMILY HEALTH HISTORY

Please complete the following charts. Additional information can be added on a blank sheet of paper.

LIVING FAMILY MEMBERS					DECEASED FAMILY MEMBERS	
HEALTH					AGE @ DEATH	CAUSE OF DEATH
(By NAME)	AGE	GOOD	FAIR	POOR		
Husband						
Wife						
Mother						
Father						
Brother(s) (by NAME)						
1.						
2.						
3.						
4.						
5.						
Sister(s) (by NAME)						
1.						
2.						
3.						
4.						
5.						
Son(s) (NAME)						
1.						
2.						
3.						
4.						
5.						
Daughter(s) (NAME)						
1.						
2.						
3.						
4.						
5.						
Paternal Grandfather						
Paternal Grandmother						
Maternal Grandfather						
Maternal Grandmother						

The following page contains a chart where more detailed information about family members listed in the chart above should be documented. Please mark an "X" in the appropriate box for any blood relative with the following conditions: **Chart to follow – page 4**

Name: Date

Family Record: Please indicate with an "X" if you or any blood relative have or have had any of the following conditions:	SELF	FATHER	MOTHER	BROTHER 1	BROTHER 2	BROTHER 3	BROTHER 4	BROTHER 5	SISTER 1	SISTER 2	SISTER 3	SISTER 4	SISTER 5	DAUGHTER 1	DAUGHTER 2	DAUGHTER 3	DAUGHTER 4	DAUGHTER 5	SON 1	SON 2	SON 3	SON 4	SON 5
Alcoholism																							
Allergies																							
Anemia																							
Arteriosclerosis																							
Arthritis																							
Asthma																							
Birth Defects																							
Bleeding Tendency																							
Cancer																							
Colitis																							
Congenital Heart																							
Diabetes																							
Emphysema																							
Epilepsy or Seizures																							
Glaucoma																							
Goiter																							
Growth or Polyp in Colon																							
Hay Fever																							
Heart Attack																							
Heart Disease																							
High Blood Pressure																							
HIV																							
Kidney Disease																							
Leukemia																							
Liver Disease																							
Lupus																							
Mental Illness																							
Nervous Breakdown																							
Obesity																							
Parkinsons																							
Rheumatism																							
Rheumatic Fever																							
Ulcer																							
Seizure History																							
Stroke																							
Suicide																							
Tuberculosis																							
Hypoglycemia																							
Crohns Disease																							
MS																							
Congenital Defect																							
Alzheimer																							
Skin Disease																							
Wear Glasses																							
Hearing Problems																							
Color Blindness																							
Varicose Veins																							
Exposure History																							
ADOPTED – PLEASE PLACE AN "A" IN COLUMN IF ADOPTED																							

Name: Date

Do you frequently have severe headaches? Yes No
If yes, answer the following:
Do they cause visual trouble? Yes No
Do they occur on one side of the head? Yes No
Do they awaken you at night from sleep? Yes No
Do they feel like a tight hat band? Yes No
Do they hurt most in the back of the head and neck? Yes No
Does aspirin relieve them? Yes No
When did you begin having headaches?

Have you recently had pain in the stomach which:
Occurs 1-2 hours after a meal? Yes No
Occurs while eating or immediately after? Yes No
Is brought on by eating fried, greasy food? Yes No
Awakens you at night? Yes No
Is relieved by antacid medications? Yes No
Is relieved with milk or eating? Yes No
Is relieved by a bowel movement? Yes No
Causes loss of appetite? Yes No
When did this pain begin?

Have you ever:
Fainted? Yes No
Had a convulsion? Yes No
Had spells of dizziness? Yes No
Had spells of weakness of an arm or leg? Yes No
Had ringing in ears? Yes No
Had double vision? Yes No
Had pain in ears? Yes No
Had nosebleeds? Yes No

Do you frequently have:
Bleeding gums? Yes No
Trouble swallowing? Yes No
Hoarseness? Yes No
A sore tongue? Yes No
Nausea and vomiting? Yes No

Have you ever had shortness of breath?
Doing your usual work? Yes No
Climbing a flight of stairs? Yes No
Which awakens you at night? Yes No
Do you have a chronic cough? Yes No
Accompanied by wheezing? Yes No
Have you ever coughed blood? Yes No
Do you cough up much sputum? Yes No

If you have had a change in bowel habit recently, answer the following:
Crampy pain in the abdomen? Yes No
Pain during or after bowel movement? Yes No
Ribbon-like stools? Yes No
Require use of strong laxatives or enemas? Yes No
If yes, when or since when?

Have you ever noticed:
Constant thirst? Yes No
Most always cold? Yes No
Too warm mostly? Yes No
Very sluggish or tired Yes No
Is our life satisfactory? Yes No
Is your life boring? Yes No
Is your life demanding? Yes No

Have you had pain or tightness in the Chest which begins:
When exerting yourself? Yes No
When walking against the wind? Yes No
When walking up a hill? Yes No
After a heavy meal? Yes No
Palpitations? Yes No
Do you sleep on more than one pillow? Yes No
Irregular heartbeat? Yes No
Radiates down the arm? Yes No
Disappears if you rest? Yes No
Occurs only at rest? Yes No
When walking fast? Yes No
When walking in cold weather? Yes No
If you have a chest pain or tightness, please explain below:_____
_____
_____
When did your chest pain begin? _____
_____

Have you had:
Loss of sexual desire? Yes No
For how long?_____
Treatment for genitals? Yes No
Burning when urinating? Yes No
Loss of control of bladder? Yes No
Dark colored urine? Yes No
Trouble holding urine? Yes No
To get up frequently at night? Yes No
Passed a kidney stone? Yes No
If yes, when or since when?
Trouble starting to urinate? Yes No
_____
_____
_____

Have you recently had:
Pains in calves of legs when walking? Yes No
Cramps in legs at night? Yes No
Pain in the big toe? Yes No
Varicose veins? Yes No
Phlebitis or inflamed leg veins? Yes No
Swelling in the ankles? Yes No
If yes, when or since when?
_____

Alternating diarrhea and constipation? Yes No
Blood in the stool? Yes No
Black stools? Yes No
Mucous in the stool? Yes No
Do you fall asleep easily? Yes No

Do you have:
Joint pain? Yes No
Joint swelling? Yes No
Muscle strength loss? Yes No
Pains in back? Yes No
Have you ever attempted suicide? Yes No
Have you ever seriously considered suicide? Yes No

Is there worry over: (circle all that apply)

Home life Marriage Job Children Parents Money

Name: Date

HABITS

DO YOU: (give brand name or type)	YES	NO	QUIT	TIME FRAME (give dates)	Usage
SMOKE					Packages per day
DRINK COFFEE					Cups per day
DRINK ALCOHOL					Ounces per day
DRINK BEER					Cans / Bottles per day
DRINK TEA					Cups per day
DRINK CARBONATED BEVERAGES					Cans per day
USE ILLICIT DRUGS					Times a week

X	Medications if taken	Dates	X	Medications if taken	Dates	X	Medications if taken	Dates
	Antacids			Dilantin			Tranquilizers	
	Antibiotics			Hormones			Vitamins	
	Aspirin, Bufferin, Anacin			Insulin, Diabetic Pills			Water Pills	
	Barbiturates			Iron or Poor Blood Medicine			Weight Reducing Pills	
	Birth Control Pills			Laxatives				
	Blood Pressure Pills			Phenobarbital				
	Blood Thinning Pills			Shots			Others (list)	
	Cortisone			Sleeping Pills				
	Cough Medicine			Thyroid Medicine				
	Digitalis			Tylenol			Vaccinations (please list)	

Have you had the Hepatitis B Vaccinations? Yes No If yes, when?_____
Have you had a flu vaccination? Yes No If yes, when?_____
Have you had the pneumonia vaccine? Yes No If yes, when?_____
Have you had any immunizations for: (circle all that apply and provide approx date or year)

Smallpox Mumps Anthrax Chicken Pox OTHERS:

Allergy	PLEASE EXPLAIN ANY ADVERSE REACTION YOU HAVE HAD TO ANY MEDICATION:

DATES/YEARS	Please list medications taken in the past

Name: Date

Please discuss **hospitalizations** (include year):

Other **Serious Illness** not requiring hospitalization (include year):

Describe any **serious injuries or accidents** you have had:

WOMEN Only:

Do you have:	yes	no	Have you ever had:	Yes	No	Please give dates
Bleeding between your periods			Bleeding between your periods			
Heavy bleeding with your periods			Heavy bleeding with your periods			
I.U.D.			I.U.D.			
Discharge from the nipple of your breast			Discharge from the nipple of your breast			
Norplant device			Norplant device			
History of abnormal pregnancy			History of abnormal pregnancy			
History of PID			Cesarean operation			
			Complications of any pregnancy			
			Miscarriage			
Bloating or irritability before your periods			Bloating or irritability before your periods			
			A stillbirth			
			A mammogram			
			A breast ultrasound			

When was your last menstrual cycle?	How long did your last menstrual cycle last?
How many days is it between your menstrual cycles?	When was your last pap smear? What was the result? Normal Abnormal
How often do you perform self-breast examinations?	Do you have regular pap smears?
How many live births have you had?	When was your last mammogram or breast ultrasound?
Have you ever been told that your cervix has been effected by DES exposure?	What birth control pills are you on or have you ever been on?

Comments (if you need additional space, please attach sheet):

MEN Only:

Have you ever had:
Discharge from penis? Yes No Hernia (rupture)? Yes No Prostate trouble? Yes No

Comments (if you need additional space, please attach sheet):

Name: Date

PLEASE DISCUSS ANY OTHER HEALTH OR MENTAL PROBLEMS THAT YOU THINK WE SHOULD KNOW ABOUT ON AN ADDITIONAL SHEET IF NECESSARY:

Part 1. Exposure History

1. Are you currently exposed to any of the following? **Circle all that apply**.
   If you (or your wife) were pregnant at the time of exposure, please indicate with asterisk (e.g. metals).*

Metals	Chemicals	Dust or fibers
Fumes	Radiation	Biologic agents (such as mold)
Loud noise	Vibration	Extreme heat or cold

Mold: Ever lived in a dwelling or work with mold, suspected mold, water damage, leaky basement, leaky roof, damp plaster walls, or owned the old Maytag Neptune front loading washer machine which is known to cause mold growth and exposure? No Yes

2. Do you have any past history of exposure to any of the above? No Yes

If you answered yes to any of the items above, describe your exposure in detail – how you were exposed, to what, when and how long. If you need more space, please use a separate sheet of paper.

3. Do any household members have contact with metals, dust, fibers, chemicals, fumes, radiation, high voltage power lines in close proximity or biologic agents ?
   No Yes
   (If biologic agent, such as toxigenic mold – please provide environmental study if available)

If yes, please provide exact name and details to the best of your knowledge.

4. Do you get the material on your skin or clothing? No Yes
5. Are your work clothes laundered at home? No Yes
6. Do you shower at work? No Yes
7. Can you smell the chemical/material you work with? No Yes
8. Do you use protective equipment such as gloves, masks, respirator, hearing protectors? No Yes

If yes, list the protective equipment used, how and when it was used.

9. Have you been advised to use protective equipment? No Yes
10. Do you wash your hands with solvents? No Yes
11. Do you smoke at the workplace? No Yes
12. Do you work with others who smoke at the workplace? No Yes
13. Do you smoke at home? No Yes
14. Do you live with a smoker? No Yes
15. Do you eat at the workplace? No Yes
16. Do you know of any coworkers experiencing similar or unusual symptoms? No Yes
17. Are family members experiencing similar or unusual symptoms? No Yes
18. Has there been a change in the health or behavior of family pets? No Yes
19. Have you noticed a change in the health or growth pattern of the vegetation surrounding work or home? No Yes
20. Are your symptoms aggravated by a specific activity? No Yes
21. Do your symptoms get either worse or better:
    At work? No Yes At home? No Yes
    On weekends? No Yes On vacation? No Yes
22. Has anything about your job changed in recent months? (such as duties, locations, procedures, overtime)? No Yes

If you answered yes to any of the questions in Part 1 (Exposure History), please explain below.

A. Occupational Profile

The following questions refer to your current or most recent job:

Job Title: _____ Type of industry: _____

Name of employer: _____

Date job began: _____ Are you still working in this job? No Yes
If no, when did this job end and why?

_____

Has there been any change in your duties or responsibilities? (If yes please explain below) No Yes
Describe job: _____

_____

_____

_____

_____

Please complete the following table listing **all** jobs you have worked including short-term, seasonal, part-time employment and military service. Begin with your most recent job. Use additional paper if necessary.

Table to follow – page 10

Dates of Employment	Job Title/Description of Work	Exposures*	Protective Equipment
1)			
2)			
3)			
4)			
5)			
6)			
7)			

*List the chemicals, dusts, fibers, fumes, radiation, biologic agents (i.e., molds, viruses) and physical agents (i.e., extreme heat, cold, vibration, noise) that you were exposed to at this job.

Have you ever worked at a job or hobby in which you came in contact with any of the following by breathing, touching or ingesting (swallowing)? If yes, please check the box beside the name.

CHEMICALS:	CONTACT YEAR (S):	CHEMICALS:	CONTACT YEAR (S):
☐ Asbestos		☐ Benzene	
☐ Beryllium		☐ Cadmium	
☐ Carbon tetrachloride		☐ Chlorinated naphthalenes	
☐ Chloroform		☐ Chloroprene	
☐ Chromates		☐ Coal dust	
☐ Dichlorobenzene		☐ Ethylene dibromide	
☐ Ethylene dichloride		☐ Fiberglass	
☐ Halothane		☐ Isocyanates	
☐ Ketones		☐ Lead	
☐ Manganese		☐ Mercury	
☐ Nickel		☐ PBB's	
☐ PCB's		☐ Perchloroethylene	
☐ Pesticides		☐ Phenol	
☐ Phosgene		☐ Radiation	
☐ Rock dust		☐ Silica powder	
☐ Solvents		☐ Styrene	
☐ Talc		☐ Toluene	
☐ TDI or MDI		☐ Trichloroethylene	
☐ Trinitrotoluene		☐ Vinyl chloride	
☐ Welding Fumes		☐ X-rays	
☐ Other (specify)			

Please attach MSDS (material safety data sheet) and details of exposure(s).

B. Occupational Exposure Inventory. Please circle the appropriate answer.

1. Have you ever been off work for more than one day because of an illness related? to work? No Yes
2. Have you ever been advised to change jobs or work assignments because of any health problems or injuries? No Yes
3. Has your work routine changed recently? No Yes
4. Is there poor ventilation in your workplace? No Yes

Name: Date

Please circle the appropriate answer.

1. Do you currently live next to or near an industrial plant, commercial business, dumpsite or nonresidential property? No Yes
2. Have you ever lived next to or near an industrial plant, commercial business, dumpsite or nonresidential property? No Yes
3. Which of the following do you have in your house? Please circle those that apply.
   Air conditioner *Air purifier* *Central heat (gas or oil)*
   Gas stove *Electric stove* *Fireplace*
   Wood stove *Humidifier*
4. Have you recently acquired new furniture or carpet, refinished furniture, or remodeled your home? No Yes
5. Are pesticides or herbicides (bug or weed killers; flea and tick sprays, collars, powders, or shampoos) used in your home or garden, or on pets? No Yes
6. Do you (or any household member) have a hobby or craft? No Yes
7. Do you work on your car? No Yes
8. Have you ever changed your residence because of a health problem? If so why, when? No Yes
9. Where does your drinking water come from? Please circle all that apply.
   A private well city water supply grocery store other:_____
10. If you have a well, please fill in the following grid.

Depth of well	Water last checked	Result:	Type of pump	Age of pump

If you answered yes to any of the questions in Part 3, please explain.

Part 4. Childhood History

Where did you grow up? Give details of your childhood such as urban, suburban or rural area.

What did your parents do for a living while you were growing up?

Nutritional Questionnaire

Do you use artificial sweeteners? Yes ☐ No ☐
Are you on a special diet? Yes ☐ No ☐
If yes, please explain _____

_____

_____

How much fluid do you usually drink per day? _____

What types of fluids? _____

Please indicate below how many servings you have of each item on an average day:

Food Types	*Servings*		
Fruit	_____ (fresh)	_____ (frozen)	_____ (canned)
Vegetables	_____ (fresh)	_____ (frozen)	_____ (canned)
Meat: beef, chicken, fish, pork etc.	_____		
Dairy: milk, cheese, yogurt etc.	_____		
Bread & Cereal	_____		
Tea (hot or iced)	_____		
Coffee	_____		
Soft drinks/carbonated beverages	_____		

How often do you eat out in restaurants? _____

Do you take vitamins/supplements? Yes ☐ No ☐
If yes, what types?

_____

_____

_____

_____

Please provide the names and specialties of any other medical provider you have seen beginning with the last provider who treated you prior to the time you experienced a significant change in your overall health. Ideally, we would like to obtain medical records to be reviewed prior to your scheduled appointment.

Name: Date

Please feel free to add any additional notes, a timeline or photographs which you think may be helpful in order to aid in understanding what has caused you to seek medical care through our facility at this time.

Name: Date

Copies of previous medical records and any relevant information should be forwarded to us prior to your first appointment. It is helpful to bring or send a printout from your pharmacy (ies) of all medications you are taking or have taken for the last year or longer if there is an extended period of concern.

Name: Date