Health Questionnaire
Please answer the following 21 questions either yes or no.

1. Are you tired most of the time?
2. Does being tired alter your lifestyle?
3. Do you have intestinal gas?
4. Do you have abdominal bloating or discomfort?
5. Do you have 1 or more bowel disorders?
6. Do you crave sugar, bread, beer or alcoholic beverages?
7. Do you have constipation or diarrhea or alternating of the two?
8. Do you have anxiety, depression, panic attacks, or mood swings?
9. Are you irritable, easily angered, anxious, or nervous?
10. Do you have trouble thinking clearly and /or have short-term memory loss?
11. Are you ever faint, dizzy or light headed?
12. Do you have muscle aches or take greater than a day to recover from normal activities?
13. Without changes in your diet have you gained weight that is difficult to shed?
14. Does itching and burning of the vagina, rectum, or prostate bother you?
15. Do you have a white or yellow fuzzy coating on your tongue?
16. Have you had athlete's foot, ringworm, jock itch, or other chronic fungal infection of the skin or nails?
17. Do perfumes, insecticides, new carpeting, or other chemical smell bother you?
18. Have you at any time in your history taken broad-spectrum antibiotics?
19. Are you taking or have you in the past taken birth control medication?
20. Are you on hormone replacement therapy?
21. Have you ever taken or had a steroid drug or had an injection for pain? (Cortisone and prednisone for allergies, asthma, respiratory problems and injuries.)