JILL C. CARNAHAN, MD, ABFM, ABHM
Flatiron Functional Medicine
75 Manhattan Drive, Suite 1
Boulder, CO 80303
Phone: 303-443-9590 **Fax: 303-443-9787**

INTEGRATIVE MEDICAL HISTORY QUESTIONAIRE

PART I: PATIENT DEMOGRAPHICS

Date: _____ Marital Status: [ ]M [ ]S [ ]W [ ]D [ ]Other

Patient Name: _____ EMAIL: _____

Address:_____ Cell phone: _____

City: _____ State: _____ Zip:_____ Home phone: _____

Age:_____ Occupation: _____SS#: _____ Work phone: _____

Sex: ___ Weight: _____ Height: _____ Birthdate: _____ Birthplace: _____

Spouse/Partner Name:_____ Occupation:_____ Age:_____ Phone:_____

Referred by:_____ Relationship: _____

Accompanied to office by:_____ Relationship:_____

Primary Language _____ Secondary Language: _____

Reason for Visit:

Please list problems and concerns

#1
#2
#3
#4
#5

PRESENT PHYSICIANS / CONCURRENT MEDICAL CARE

If you are now being treated by another physician or physical or mental health practitioner, please describe each problem and write the name of the physician, health practitioner or medical facility treating you.

Name of Primary Care Physician	
Office contact information	
Other physicians involved in your care	
:	

PART 2: TIMELINE OF MEDICAL ILLNESS(ES)

Please provide history for each major problem. Begin with the onset of each problem and indicate doctors' visits, doctors' names, diagnoses, procedures, and results, and whether they were effective or ineffective.

(1) PROBLEM/DIAGNOSIS *(specify):*

When did the problem begin?	What symptoms were present?
Was there pain? [ ]Yes [ ]No Where?	How much pain? (*on scale of 1 to 10 – circle please*) 1 2 3 4 5 6 7 8 9 10
Describe the course or progression of this problem.	
Did anything make problem better?	Did anything make it worse?
What tests/procedures were done?	
When were they done?	Where were they done?
Were you hospitalized for this condition? [ ]Yes [ ]No Where?	If yes, when were you hospitalized, and for how long?
What has happened to the problem since treatment until today?	
What medications or supplements are you taking for this condition?	

(2) PROBLEM/DIAGNOSIS *(specify):*

When did the problem begin?	What symptoms were present?
Was there pain? [ ]Yes [ ]No Where?	How much pain? (*on scale of 1 to 10 – circle please*) 1 2 3 4 5 6 7 8 9 10
Describe the course or progression of this problem.	
Did anything make problem better?	Did anything make it worse?
What tests/procedures were done?	
When were they done?	Where were they done?
Were you hospitalized for this condition? [ ]Yes [ ]No Where?	If yes, when were you hospitalized, and for how long?
What has happened to the problem since treatment until today?	
What medications or supplements are you taking for this condition?	

(3) PROBLEM/DIAGNOSIS *(specify):*

When did the problem begin?	What symptoms were present?
Was there pain? [ ]Yes [ ]No Where?	How much pain? (*on scale of 1 to 10 – circle please*) 1 2 3 4 5 6 7 8 9 10
Describe the course or progression of this problem.	
Did anything make problem better?	Did anything make it worse?
What tests/procedures were done?	
When were they done?	Where were they done?
Were you hospitalized for this condition? [ ]Yes [ ]No Where?	If yes, when were you hospitalized, and for how long?
What has happened to the problem since treatment until today?	
What medications or supplements are you taking for this condition?	

(4) PROBLEM/DIAGNOSIS *(specify):*	
When did the problem begin?	What symptoms were present?
Was there pain? [ ]Yes [ ]No Where?	How much pain? (*on scale of 1 to 10 – circle please*) 1 2 3 4 5 6 7 8 9 10
Describe the course or progression of this problem.	
Did anything make problem better?	Did anything make it worse?
What tests/procedures were done?	
When were they done?	Where were they done?
Were you hospitalized for this condition? [ ]Yes [ ]No Where?	If yes, when were you hospitalized, and for how long?
What has happened to the problem since treatment until today?	
What medications or supplements are you taking for this condition?	

PAST MEDICAL HISTORY

Please list any medical conditions you have been diagnosed or treated for ever

	YEAR	ILLNESS	YEAR	ILLNESS	YEAR
Measles		Diabetes		HIV /AIDS	
Mumps		Heart disease		Food allergies	
Diptheria		Heart attack		Kidney disease	
Pertussus		Stroke		Bladder infections	
Polio		Thyroid disease		Arthritis	
Meningitis		Gallbladder disease		Back pain	
Influenza		Inflammatory bowel disease		headaches	
Chicken Pox		Hemorroids		Anemia	
Chlamydia		Jaundice/liver disease		Seizures	
Gonorrhea		Depression		Epilepsy	
Hepatitis		Anxiety/panic attacks		Fainting/dizziness	
Tuberculosis		Insomnia/sleep disorder		Lung disease	
Asthma		Swelling/edema		OTHER	
Allergies		Arthritis/joint pain			
Eczema		Muscle disease			
Hives		Cancer (which type?)			

HOSPITALIZATIONS / SURGERIES

List all times (and reasons) you have been hospitalized, operated on, or severely injured.

Date	Hospital admissions, procedures (what & why) for all illnesses, injuries	Doctor & Medical Facility

FAMILY HEALTH HISTORY

	Relationship		Relationship
Heart condition		Cancer	
Heart attack		Epilepsy	
High blood pressure		Seizure disorder	
Stroke		Nervous breakdown	
Bleeding disorder		Mental disorder	
Tuberculosis		Alcoholism/Drug Addiction	
Diabetes		Suicide/Attempted Suicide	

Immediate Family		Age		Present health	Deceased ?		Age at death		Year of death		Cause of death
Father											
Mother											
Brother[ ] Sister[ ]											
Brother[ ] Sister[ ]											
Brother[ ] Sister[ ]											
Brother[ ] Sister[ ]											
Brother[ ] Sister[ ]											

PART 4: PRESENT AND PAST SYMPTOMS

CURRENT SYMPTOMS

Please mark with an (X) any illnesses or medical problems you have, or have had, within the past year.

SYMPTOMS	(X)	DATE STARTED	SYMPTOMS	(X)	DATE STARTED
Frequent or severe headaches			Spots before eyes		
Fainting spells			Frequent eye infections		
Dizziness on change of position			Eye pain		
Unconscious spells			Change in vision		
Blurred vision			Eyeglasses needed		
Earaches			Recurrent head colds		
Discharge from ears			Sinus trouble		
Ringing in ears			Hay fever/allergies		
Decrease in hearing			Persistent body odor		
Recurrent nose bleeds			Recurrent sore throats		
Strange taste or loss in taste			Recurrent mouth sores		
Persistent hoarseness			Soreness/bleeding gums		
Difficulty swallowing			Dentures?		
Swollen lymph nodes			Pain in arms or legs		
Chest pain			Restless legs		
Chest pain			Palpitations/fluttering of heart		
Coughing up blood			High blood pressure		
Frequent cough			Swelling of hands, feet or ankles		
Frequent sinus infections			Leg cramps while walking or reclining?		
Wake up nights, short of breath			At what time of day?		
How many bed pillows at night?			Varicose veins		
Shortness of breath when:			Nausea or vomiting		
- Walking several blocks			Vomiting blood		
- Ascending flight of stairs			Avoiding any foods? (list)		
- Lying down or reclining			What kinds?		
Cold or discolored lips/fingers			Avoiding spices? (list)		
Recurrent stomach pain			Rectal pain with bowel movement		
Belching or hearburn			Blood in bowel movement		
Appetite: Good, Fair, or Poor			Full bladder feeling but little urination		
Abdominal cramping/pain			Urinate less than usual		
Change in bowel movement?			Lose urine on coughing, sneezing or laughing		
Color of bowel movement (describe)			Discharge from penis/vagina		
Blood in stool?			Blood in urine?		
Pain on urinating			Tingling or weakness of hands or feet		
Getting up at night to urinate			Redness or heat in joints		
How many times?			Muscle spasms		
Urinating frequently			Dry skin		
Difficulty starting urination			Easy bruising		
Recurrent backaches or pain			Inability to tolerate heat		
Joint pain			Inability to tolerate cold		
Swelling of any joints			Change in hair texture/hair loss		
Loss or change in sensation of hands or feet			Change in skin texture		
Tremor/shaking of extremities			Skin rashes		
Swollen neck or throat			Difficulty concentrating		
Hot flashes/night sweats			Poor memory		
Fatigue without obvious reason			Depressed mood		
Brittleness of nails			Anxiety		

LIST ALL CURRENT MEDICATIONS AND SUPPLEMENTS

List all medications, vitamins, or supplements you are now taking, including those you buy with/without a doctor's prescription.

Name	Dosage	Times per Day	Reason

Any hormones (estrogens, progesterone, dhea, testosterone, growth hormone, steroids)

IMMUNIZATIONS / VACCINATIONS

Check [X] any you received	X	When?	Boosters	X	When?	Describe any adverse reactions
Smallpox			Within past 7 years?			
DPT						
Diphtheria						
Check [X] any you received	**X**	**When?**	**Boosters**	**X**	**When?**	**Describe any adverse reactions**
Pertussis						
Tetanus			Tetanus booster?			
Measles						
Mumps						
Rubella						
Polio			Within past 2 years?			
Hepatitis						
Influenza (flu)			Your last Flu shot?			
Pneumovax						
Other (specify)						

Have you been out of the country in the last 2 years? [ ]No [ ]Yes When: Where:

Tuberculin (TB) skin test? When: Positive[ ] Negative[ ]

ALLERGIES, SENSITIVITIES & INTOLERANCES

List anything that you are allergic to such as specific foods, medications, dust, chemicals, etc., and indicate how each affects you (e.g., congestion, headache, hives, difficulty breathing, dizzy, etc.)

Allergic, Sensitive, Intolerant to:		*Effect:*

Do you live with a pet? No[ ] Yes[ ] Any reactions? No[ ] Yes[ ]

What kind of pet(s)? How many? How long?

To consider environmental/chemical exposures, list relevant jobs you have held.

WEIGHT HISTORY

Your present weight?	Your weight 1 year ago?	Your weight 5 years ago?
Your MAXIMUM adult weight?	When?	What do you consider ideal weight?
Your MINIMUM adult weight?	When?	
Any circumstances surrounding extremes of weight?		

PART 5: FOR WOMEN ONLY

Menstrual History

Age and year periods began (onset of menarche)
Date of LMP (last menstrual period)
How many days from start of one period to start of next?
How many days does your period last?
Is your cycle regular? [ ]yes [ ]no
Do you pass any clots?
Is the flow heavy ____, medium ____, or light ____?
How many pads ____, tampons ___ used on heavy days?
Do you have cramps BEFORE period? [ ]yes [ ]no
DURING period? [ ]yes [ ]no
Any change in breast size? [ ]yes [ ]no
Do you examine your breasts? [ ]yes [ ]no
Do you experience tender breasts? [ ]yes [ ]no If so, when?
Nipple discharge? [ ]yes [ ]no If so, what color?
Date of last mammogram and findings
Age and year of menopause
Do you have hot flashes? [ ]yes [ ]no
Ever taken estrogen or hormone replacements (HRT)? [ ]yes [ ]no
Age and year at time of estrogen/HRT
Date of last pelvic/gynecological exam and result of exam
Date of last pap test and result of test
Do you experience itching or burning of vaginal area? [ ]yes [ ]no
Do you experience discharge from vagina? [ ]yes [ ]no
If so, Amount: _____ Color: _____ When began?

Birth Control Methods

Have you used Pills? [ ]yes [ ]no
Have you used an IUD? [ ]yes [ ]no
If so, what type?
Describe any problems with pills or IUD

Pregnancies

Have you ever been pregnant? [ ]yes [ ]no		
How old were you during pregnancies?		
Describe any complications with pregnancies/deliveries:		
Did you breastfeed? [ ]yes [ ]no If so, how long?		
Number of miscarriages		Any medical complications?
Number of stillbirths		Reason give
Number of premature births		Reason given:
Number of Cesarean sections		Reason given:
Number of abortions?		Reason:

PART 6: PERSONAL HYGIENE & LIFE STYLE

How often do you brush your teeth?			Do you use enemas?	[ ]yes [ ]no
How many minutes each time?			What kind and for what purpose?	
Do you use fluoridated toothpaste?	[ ]yes [ ]no		Do you use vaginal douches?	[ ]yes [ ]no
What type of dental floss do you use? waxed[ ] unwaxed[ ] none[ ]			What kind and for what purpose?	
How often do you use dental floss?			Do you take saunas or steam baths?	[ ]yes [ ]no
Do you use antiseptic mouthwash?	[ ]yes [ ]no		Are you right-handed?	[ ]yes [ ]no
Do you use deodorants?	[ ]yes [ ]no		Left-handed?	[ ]yes [ ]no
Do you use antiperspirant	[ ]yes [ ]no		Ambidextrous?	[ ]yes [ ]no

SMOKING / ALCOHOL / DRUG HISTORY

SMOKING		ALCOHOL	
Do you smoke?	[ ]yes [ ]no	How many drinks do you normally have?	
How many years?		Beer	_____per day / week / month
Have you ever smoked?	[ ]yes [ ]no	Wine	_____per day / week / month
How many years?		Hard liquor	_____per day / week / month
Stopped when?		Have you ever had a problem with alcohol?	[ ]yes [ ]no
Cigarettes, packs/day		Where were you treated?	[ ]yes [ ]no
How many Cigars/ day?			
How many Pipes/day?		DRUG USE	
Co-workers smoke?	[ ]yes [ ]no	Have you ever used drugs?	[ ]yes [ ]no
How many years?		Have you ever smoked marijuana?	[ ]yes [ ]no
How many hours/day?		Have you ever used "hard" drugs?	[ ]yes [ ]no
Anyone smoke at home?	[ ]yes [ ]no	Which drugs?	
How many hours/day?		How many years?	
Do you drink alcohol?	[ ]yes [ ]no	Were you ever treated for drug use?	[ ]yes [ ]no
How many years?		Where were you treated?	

EXERCISE HISTORY

Are you now more or less capable physically than you were at age 17-18? **[ ]**More **[ ]**Same **[ ]**Less
Do you have time for exercise? **[ ]**No **[ ]**Yes Could you make time for exercise? **[ ]**No **[ ]**Yes

Put a check mark alongside activities in which you do or did engage.

Activity		Activity	
Jog	[ ]Now [ ]Past [ ]Daily [ ]Weekly [ ]Monthly	Isometrics	[ ]Now [ ]Past [ ]Daily [ ]Weekly [ ]Monthly
Run	[ ]Now [ ]Past [ ]Daily [ ]Weekly [ ]Monthly	Bicycling	[ ]Now [ ]Past [ ]Daily [ ]Weekly [ ]Monthly
Swim	[ ]Now [ ]Past [ ]Daily [ ]Weekly [ ]Monthly	Garden	[ ]Now [ ]Past [ ]Daily [ ]Weekly [ ]Monthly
Lift Weights	[ ]Now [ ]Past [ ]Daily [ ]Weekly [ ]Monthly	Breath Exercises	[ ]Now [ ]Past [ ]Daily [ ]Weekly [ ]Monthly
Walk	[ ]Now [ ]Past [ ]Daily [ ]Weekly [ ]Monthly	Martial Arts	[ ]Now [ ]Past [ ]Daily [ ]Weekly [ ]Monthly
Dance	[ ]Now [ ]Past [ ]Daily [ ]Weekly [ ]Monthly	OTHER (specify)	

ENVIRONMENT

Check any of the following that create stress for you at work or home

[ ]Chemicals	[ ]Spring [ ]Summer
[ ]Pollution	[ ]Fall
[ ]Exhaust	[ ]Winter
[ ]Poor Air Ventilation	[ ]Cold
[ ]Lighting	[ ]Heat
[ ]Lack of Sunshine	[ ]Noise
[ ]Lunar Cycles	[ ]Deadlines
[ ]High Humidity	[ ]Pressure to perform
[ ]Dampness	[ ]Relationship with Co-workers
[ ]Season Change	[ ]Relationship with household members
Do you adapt well to change? [ ]yes [ ]no	[ ]Other (specify):

SLEEP PATTERN

How many sleep hours do you need?
Describe how you fall asleep:
Do you have trouble falling asleep? [ ]yes [ ]no
If you awaken during the night, how often?
When you awaken at night, do you have trouble falling back to sleep? [ ]yes [ ]no
Are your sleep habits routine? [ ]yes [ ]no
Do you have trouble waking up in the morning? [ ]yes [ ]no
What time of day are you most awake and alert? From To

DAILY ACTIVITIES

Describe how your "typical" day usually unfolds from morning to night with approximate times.

(A.M.) Morning:
(P.M.) Afternoon:
Evening (5:00 - 7:00):
(P.M.) Night:
Weekend:

FOR MEN AND WOMEN
- SEXUAL PATTERNS -

What is your attitude towards sex?
Do you have any questions or concerns about sex?
Is your present sex life satisfactory? [ ]Yes [ ]No
Do you have any pain or discomfort with sexual intercourse? [ ]Yes [ ]No If yes, please explain:
How many partners have you had in the past ten years?
What is the frequency of your present sexual activity?
Do you practice birth control? [ ]Yes [ ]No If yes, please describe what type:
Do you have any questions about birth control?
If you have used any form of birth control, please indicate how long. IUD:_____ Diaphragm:_____ Foam:_____ Condoms:_____ Pill:_____ Other:_____
Do you find your present method satisfactory for your experience of sex? [ ]Yes [ ]No
Do you find your present method satisfactory for your health? [ ]Yes [ ]No
Do you have any problems with or questions about venereal disease? [ ]Yes [ ]No
Have you ever had a sexually transmitted disease? [ ]Yes [ ]No If yes, please explain:

PART 7: STRESS & SATISFACTION

STRESS RATING SCALE

Check (X) stresses you have or have had. If experienced within the last 3 years, add a check mark (√).

SCORE	X	√	LIFE EVENT / SITUATION	SCORE	X	√	LIFE EVENT / SITUATION
100			Death of spouse	29			Trouble with in-laws
75			Divorce	28			Outstanding personal achievement
65			Separation from spouse or relationship	26			Began new work or stopped working
65			Incarceration	26			Began or ended school
65			Death of close family member	25			Change in living conditions
55			Personal injury or illness	24			Revision of personal habits
50			Marriage	23			Trouble with boss
47			Fired from job	20			Change in work hours or conditions
45			Marital or similar reconciliation	20			Change in residence
44			Retirement	20			Change in schools
44			Change in health of family member	19			Change in recreation
40			Pregnancy	19			Change in religious activities
39			Sex difficulties	18			Change in social activities
39			Addition to family	17			Mortgage/loan less than $10,000
39			Business readjustment	16			Change in sleeping habits
38			Change in financial state	15			Change in eating habits
37			Death of close friend	15			Change in family get-togethers
36			Change to different line of work	13			Stressful experience of holidays
35			Change in argument style with spouse				Abortion (Yourself, if female) (Your spouse or girlfriend, if male)
31			Mortgage over $10,000				
30			Foreclosure of mortgage or loan				
29			Change in responsibilities at work				
29			Son or daughter leaving home				
			Other, specify (assign your own number)				Other, specify (assign your own number)

PERSONAL STRESS CONCERNS

Is there anything about your present behavior that you would like to change? If so, what?

Are there situations in your life currently causing problems, or ones you would like to change?

Do you use stress reduction techniques [ ] YES [ ] NO If so, describe:

What do you do for enjoyment or relaxation?

STRESS RESPONSE

How are you handling your feelings about illness and treatment?

Number from 1 (your most probable response) to 6 (your least probable response).

	Keep your feelings to yourself.
	Maintain a calm appearance to those around you.
	You would discuss your feelings openly and constructively.
	Question the validity of what you were told.
	You would become depressed and experience feelings of hopelessness.
	Get angry and upset.

EMPLOYMENT & EDUCATION

Do you enjoy your work and daily activities?	[ ]Yes [ ]No
Do you feel a personal responsibility for your work?	[ ]Yes [ ]No
Are you in the right work, fulfilled by your place in life?	[ ]Yes [ ]No
Does your work provide you with the necessities of life?	[ ]Yes [ ]No
Do you get self-satisfaction out of your work?	[ ]Yes [ ]No
If no, what motivates you to work?	[ ]Yes [ ]No

Have you made significant occupational changes in the last 10 years? [ ]Yes [ ]No
If yes, describe them briefly:

Please indicate the highest level of education completed: _____

PRIORITIES

Number the following with **1** as the most important to you, ending with **8** as the least important. Then indicate how satisfied you are with each of these aspects of your life. *Scale from (0) very dissatisfied to (3) very satisfied*.

Order of Importance	Scale 1-3	
		Vitality and performance
		Associations / relationships (family, friends)
		Appearance
		Longevity
		Libido (sexual drive)
		Solace (freedom from pain)
		Security / Safety (physical and emotional)
		Recognition / Acknowledgment for your work

PART 8: LIFE PATTERN & PERSONAL PERSPECTIVE

Section I: Life Events & Life Context

FAMILY LIFE:
Give an impression of the atmosphere of the home in which you grew up.
Include: compatibility between parents, between parents and children, attitudes toward education, type of discipline, etc.:

Briefly describe any major life events or crises during:

Childhood:

Adolescence:

Early childhood:

Recent years:

RELATIONSHIPS – A

Who are the most important people in your life?

Name		Relationship

RELATIONSHIPS – B

Describe your marriage(s) or long term relationships:

Describe your divorce(s) or separations:

Describe your present relationship:

RELATIONSHIPS – C

How many children are in the family in which you were raised?

Where do you fit in the birth order? You were #_____ child out of _____children

Mark the box next to the words that describe your childhood (and add others that might apply)
[ ]happy [ ]good [ ]fair [ ]unhappy [ ]terribly depressing [ ]verbally abusive [ ]physically abusive [ ]other_____

RELATIONSHIPS – D

Describe the quality of your relationships with people in general (include co-workers):

Describe the quality of your relationships with your family and in-laws:

RELATIONSHIPS – E

Indicate by number(s) which of the following words or phrases best describe these people:

Father	1 - Warm and affectionate	7 - Fearful and anxious, distrustful
	2 - Trusting	8 - Irate and angry
Mother	3 - Perfectionist and driven	9 - Self-reliant
	4 - Selfish	10 - Hungry for approval and recognition
Other (guardian)	5 - Selfless and always doing for others	11 - Needing to be with people
	6 - Insecure	12 - Uncomfortable with intimacy
		13 - Very concerned about personal health and well-being
YOU		

Section III: Health Beliefs

What are your expectations from this visit?
Would you like to discuss the religious or spiritual implications of your healthcare?
Do your religious or spiritual beliefs impact your treatment decisions? [ ]Yes [ ]No
In what ways do you intend to participate in increasing your healthcare?
What do you believe is your role in treating your illness?

PART 9: DIETARY PATTERNS

EATING HABITS - Section 1

Where were you born?	Country			State/Province				City		
What was the general geographic climate?										
		NO	**YES**			**NO**	**YES**		**NO**	**YES**
Infant/ Childhood Diet	Breast fed				American				Vegetarian		
	Bottle fed				Macrobiotic				Other (explain):		
Explain, if you indicated Other:										
						NO	**YES**			**NO**	**YES**
Adult Diet					American				Vegetarian		
					Macrobiotic				Other (explain):		
Explain, if you indicated Other:										
						NO	**YES**			**NO**	**YES**
Present Diet					American				Vegetarian		
					Macrobiotic				Other (explain):		
Explain, if you indicated Other:										
Was your childhood diet similar to your present one?										**NO**	**YES**
How many meals do you now eat per day?											
Describe your dining atmosphere:											
What % of your meals are eaten at home?					What % are eaten out?						
What % of the food you eat is raw?					What % is cooked?						
What energy source do you use for cooking? Gas[ ] Electric[ ] Microwave[ ]											
Describe your present appetite:											
What foods or mixtures do you avoid and why do you avoid them?											
What are your favorite flavors? Sweet[ ] Salty[ ] Sour[ ] Bitter[ ] Pungent[ ] Spicy[ ]											
When you have intense food cravings, which foods (or types of foods) do you usually crave?											
Most intense craving											
Sometimes crave											
Least intense craving											
What did you eat and drink yesterday?											
Breakfast	**Lunch**			**Dinner**				**Snacks**		**Beverages**	

PRESENT EATING HABITS – Section 2

Enter how much or how often you eat or drink each item listed: per day (Dy), per week (Wk), or per month (Mo):

	Dy	Wk	Mo
DAIRY			
Milk			
Cheese			
Yogurt			
Ice Cream			
Ice Milk			
EGGS			
MEAT			
Beef , Burgers			
Lamb			
Pork/Bacon/Ham			
Hot Dogs			
Cold Cuts			
Veal			
Chicken			
Turkey			
Fish			
Shellfish			
FATS			
Butter			
Margarine			
Cream			
Vegetable Oil			
Fried Foods			
Fat Substitute			
Other			
	Dy	**Wk**	**Mo**
SWEETS			
Sugar			
Sugar Substitute			
Honey			
Chocolate			
Candy			
Desserts			
Jams, Jellies			

	Dy	Wk	Mo
FRUIT			
Fresh			
Frozen			
Dried			
Canned			
VEGETABLES			
Fresh			
Raw, or Salad			
Frozen			
Sprouts			
Juices			
Canned			
LEGUMES			
Tofu, Tempeh			
Beans, Peas			
Lentils, Others			
Nuts, Seeds			
Nut Butters			
Seed Butters			
GRAINS			
Whole Grains:			
Brown Rice			
Pasta, whole gr			
Oatmeal			
Whole Wheat, Bulgur			
Flour, Whole Wheat			
Bread, Whole Grain			
Dy	**Wk**	**Mo**	
Refined Grains:			
White Rice			
White Flour Products			
Breakfast Cereal			
Pasta			
Other			

	Dy	Wk	Mo
LIQUIDS, BEVERAGES			
Water:			
City			
Well			
Spring			
Distilled			
Sodas (non-colas)			
Herbal Tea			
Decaf Coffee			
CAFFEINATED BEVERAGES			
Coffee (with caffeine)			
Tea (regular)			
Cola, Diet Cola			
Chocolate			
CONDIMENTS			
Salt			
Salt Substitute			
Salty Foods			
Pickles, Olives			
Pepper			
Spices			
Herbs			
ALCOHOL			
Beer			
Wine			
Distilled Spirits			
Dy	**Wk**	**Mo**	
SUPPLEMENTS			
Bran			
Wheat Germ			
Yeast			
Lecithin			
Protein Powder			