

JILL C. CARNAHAN, MD, ABFM, ABHM

Flatiron Functional Medicine

400 McCaslin Blvd. Suite 210

Louisville, CO 80027

Phone: 303-993-7910

Fax: 303-993-4674

All of the information herein will be treated in accordance with all applicable confidentiality laws and practices and is intended solely for the use of Dr. Jill Carnahan, MD

INTEGRATIVE MEDICAL HISTORY QUESTIONNAIRE

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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No Where?	How much pain? (<i>on scale of 1 to 10 – circle please</i>) 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No Where?	How much pain? (<i>on scale of 1 to 10 – circle please</i>) 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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?	

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		

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.)

<i>Allergic, Sensitive, Intolerant to:</i>	<i>Effect:</i>
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?	<input type="checkbox"/>]yes <input type="checkbox"/>]no
How many minutes each time?		What kind and for what purpose?	
Do you use fluoridated toothpaste?	<input type="checkbox"/>]yes <input type="checkbox"/>]no	Do you use vaginal douches?	<input type="checkbox"/>]yes <input type="checkbox"/>]no
What type of dental floss do you use? waxed <input type="checkbox"/>] unwaxed <input type="checkbox"/>] none <input type="checkbox"/>]		What kind and for what purpose?	
How often do you use dental floss?		Do you take saunas or steam baths?	<input type="checkbox"/>]yes <input type="checkbox"/>]no
Do you use antiseptic mouthwash?	<input type="checkbox"/>]yes <input type="checkbox"/>]no	Are you right-handed?	<input type="checkbox"/>]yes <input type="checkbox"/>]no
Do you use deodorants?	<input type="checkbox"/>]yes <input type="checkbox"/>]no	Left-handed?	<input type="checkbox"/>]yes <input type="checkbox"/>]no
Do you use antiperspirant	<input type="checkbox"/>]yes <input type="checkbox"/>]no	Ambidextrous?	<input type="checkbox"/>]yes <input type="checkbox"/>]no

SMOKING / ALCOHOL / DRUG HISTORY

SMOKING		ALCOHOL	
Do you smoke?	<input type="checkbox"/>]yes <input type="checkbox"/>]no	How many drinks do you normally have?	
How many years?		Beer	_____ per day / week / month
Have you ever smoked?	<input type="checkbox"/>]yes <input type="checkbox"/>]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?	<input type="checkbox"/>]yes <input type="checkbox"/>]no
Cigarettes, packs/day		Where were you treated?	<input type="checkbox"/>]yes <input type="checkbox"/>]no
How many Cigars/day?			
How many Pipes/day?		DRUG USE	
Co-workers smoke?	<input type="checkbox"/>]yes <input type="checkbox"/>]no	Have you ever used drugs?	<input type="checkbox"/>]yes <input type="checkbox"/>]no
How many years?		Have you ever smoked marijuana?	<input type="checkbox"/>]yes <input type="checkbox"/>]no
How many hours/day?		Have you ever used "hard" drugs?	<input type="checkbox"/>]yes <input type="checkbox"/>]no
Anyone smoke at home?	<input type="checkbox"/>]yes <input type="checkbox"/>]no	Which drugs?	
How many hours/day?		How many years?	
Do you drink alcohol?	<input type="checkbox"/>]yes <input type="checkbox"/>]no	Were you ever treated for drug use?	<input type="checkbox"/>]yes <input type="checkbox"/>]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	<input type="checkbox"/>]Now <input type="checkbox"/>]Past <input type="checkbox"/>]Daily <input type="checkbox"/>]Weekly <input type="checkbox"/>]Monthly	Isometrics	<input type="checkbox"/>]Now <input type="checkbox"/>]Past <input type="checkbox"/>]Daily <input type="checkbox"/>]Weekly <input type="checkbox"/>]Monthly
Run	<input type="checkbox"/>]Now <input type="checkbox"/>]Past <input type="checkbox"/>]Daily <input type="checkbox"/>]Weekly <input type="checkbox"/>]Monthly	Bicycling	<input type="checkbox"/>]Now <input type="checkbox"/>]Past <input type="checkbox"/>]Daily <input type="checkbox"/>]Weekly <input type="checkbox"/>]Monthly
Swim	<input type="checkbox"/>]Now <input type="checkbox"/>]Past <input type="checkbox"/>]Daily <input type="checkbox"/>]Weekly <input type="checkbox"/>]Monthly	Garden	<input type="checkbox"/>]Now <input type="checkbox"/>]Past <input type="checkbox"/>]Daily <input type="checkbox"/>]Weekly <input type="checkbox"/>]Monthly
Lift Weights	<input type="checkbox"/>]Now <input type="checkbox"/>]Past <input type="checkbox"/>]Daily <input type="checkbox"/>]Weekly <input type="checkbox"/>]Monthly	Breath Exercises	<input type="checkbox"/>]Now <input type="checkbox"/>]Past <input type="checkbox"/>]Daily <input type="checkbox"/>]Weekly <input type="checkbox"/>]Monthly
Walk	<input type="checkbox"/>]Now <input type="checkbox"/>]Past <input type="checkbox"/>]Daily <input type="checkbox"/>]Weekly <input type="checkbox"/>]Monthly	Martial Arts	<input type="checkbox"/>]Now <input type="checkbox"/>]Past <input type="checkbox"/>]Daily <input type="checkbox"/>]Weekly <input type="checkbox"/>]Monthly
Dance	<input type="checkbox"/>]Now <input type="checkbox"/>]Past <input type="checkbox"/>]Daily <input type="checkbox"/>]Weekly <input type="checkbox"/>]Monthly	OTHER (specify)	

ENVIRONMENT

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

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

SLEEP PATTERN

How many sleep hours do you need?
Describe how you fall asleep:
Do you have trouble falling asleep? <input type="checkbox"/> yes <input type="checkbox"/> no
If you awaken during the night, how often?
When you awaken at night, do you have trouble falling back to sleep? <input type="checkbox"/> yes <input type="checkbox"/> no
Are your sleep habits routine? <input type="checkbox"/> yes <input type="checkbox"/> no
Do you have trouble waking up in the morning? <input type="checkbox"/> yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any pain or discomfort with sexual intercourse? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you find your present method satisfactory for your health? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any problems with or questions about venereal disease? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had a sexually transmitted disease? <input type="checkbox"/> Yes <input type="checkbox"/> 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)

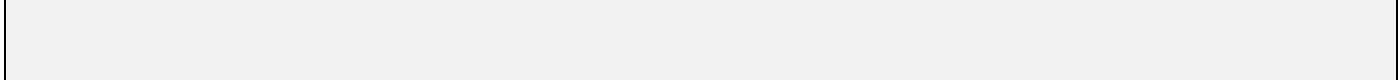
PERSONAL STRESS CONCERNS	
	Is there anything about your present behavior that you would like to change? If so, what?
	Are there situations in your life currently causing problems, or ones you would like to change?
	Do you use stress reduction techniques [] YES [] NO If so, describe:
	What do you do for 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

	<p>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.:</p>
	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			

