

CDSA^{2.0} *Medical History Questionnaire*

Patient Name _____ *Date* _____

Instructions: In each section, check the appropriate items to indicate your current symptoms, your risk factors, and your personal/family medical history.

Section 1: Irritable Bowel Syndrome (IBS) —Modified Rome Criteria

At least two days a week, I experience...

- change in bowel movement frequency (diarrhea, constipation)
- noticeable difference in stool form (shape, size, consistency)
- passage of mucus in stools
- bloating or feeling of abdominal distension (swelling of stomach)
- abnormal stool passage (straining, urgency, feeling of incomplete evacuation)
- first bowel movement within 30 minutes of arising

For the last 3 or more months I have experienced continuous or recurring abdominal (stomach) pain/irritation that:

- is relieved with a bowel movement
- occurs with a change in bowel movement frequency
- is related to a change in stool consistency

Section 2: Inflammatory Bowel Disease (IBD)

- Personal or family history of IBD (ulcerative colitis or Crohn's disease)
- Recurrent abdominal (stomach) pain
- Nighttime abdominal pain that interferes with sleep
- Recurrent diarrhea
- Nighttime diarrhea that interferes with sleep
- Blood in stool
- Pus in stool
- Fever
- Weight loss

Section 3: Colorectal Cancer

- | | |
|--|--|
| <input type="checkbox"/> Blood-related family member diagnosed with colorectal cancer | <input type="checkbox"/> Previous inflammatory disease of the colon (ulcerative colitis) |
| <input type="checkbox"/> Personal history of other cancers | <input type="checkbox"/> Diagnosis with colon polyps |
| <input type="checkbox"/> Diet high in fat, protein, calories, alcohol, and meat (both red and white) | <input type="checkbox"/> Blood in stools |
| <input type="checkbox"/> Diet low in fiber, calcium, or folate (green leafy vegetables) | <input type="checkbox"/> Unexplained weight loss |
| <input type="checkbox"/> Sedentary (physically inactive) lifestyle | <input type="checkbox"/> Narrow stool diameter |
| <input type="checkbox"/> Overweight | <input type="checkbox"/> Recurrent abdominal (stomach) pain |
| <input type="checkbox"/> Over 50 years old | <input type="checkbox"/> Recurrent constipation/diarrhea |
| | <input type="checkbox"/> Genetic risk of colon cancer (see DetoxiGenomic™ Profile) |

Section 4: Food Allergy

(Check only symptoms often experienced within 1-2 hours after eating)

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|---|---|
| <input type="checkbox"/> Bloating/indigestion | <input type="checkbox"/> Abdominal (stomach) pain |
| <input type="checkbox"/> Hives (skin rash) | <input type="checkbox"/> Difficulty breathing |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Nausea, vomiting |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Swollen tongue/lips |
| <input type="checkbox"/> Cramps | |

Section 5: Pancreatic Insufficiency

- | | |
|--|--|
| <input type="checkbox"/> Over 35 years old | <input type="checkbox"/> Unexplained weight loss |
| <input type="checkbox"/> Gallstones | <input type="checkbox"/> Chronic abdominal (stomach) pain |
| <input type="checkbox"/> Previous surgical removal of gall bladder | <input type="checkbox"/> Food allergy/intolerance |
| <input type="checkbox"/> Loose, watery stools | <input type="checkbox"/> Connective tissue disease (eg, lupus, rheumatoid arthritis, Sjögren's syndrome) |
| <input type="checkbox"/> Fatty and foul-smelling stools | <input type="checkbox"/> Personal or family history of cystic fibrosis |
| <input type="checkbox"/> Undigested food in the stools | <input type="checkbox"/> Personal history of alcoholism, diabetes, or osteoporosis |
| <input type="checkbox"/> Nausea | |
| <input type="checkbox"/> Acid reflux/heartburn | |
| <input type="checkbox"/> Bloating/indigestion | |

Section 6: Parasite Infection

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|--|---|
| <input type="checkbox"/> Loose, watery stools | <input type="checkbox"/> Unexplained weight loss |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Dehydration |
| <input type="checkbox"/> Abdominal (stomach) pain | <input type="checkbox"/> Travel abroad, particularly in developing countries |
| <input type="checkbox"/> Chills/fever | <input type="checkbox"/> Recent exposure—via physical contact or drinking water—to potential sources of contamination: recreational water (eg, swimming pools, lakes, hot tubs), child-care centers, hiking/camping, agricultural (animal) run-off. |
| <input type="checkbox"/> Blood or mucus in stool | <input type="checkbox"/> Recent contact with animals, pets |
| <input type="checkbox"/> Headache | |
| <input type="checkbox"/> Chronic fatigue | |
| <input type="checkbox"/> Skin rash | |
| <input type="checkbox"/> Excessive gas or bloating | |
| <input type="checkbox"/> Vomiting | |

Section 7: *H. pylori* infection

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|--|---|
| <input type="checkbox"/> Burning or gnawing abdominal pain that may improve after eating but returns later | <input type="checkbox"/> Non-ulcer dyspepsia ("sour stomach") |
| <input type="checkbox"/> Change in appetite with weight gain or weight loss | <input type="checkbox"/> Personal or family history of duodenal or gastric cancer |
| <input type="checkbox"/> Nausea or vomiting | <input type="checkbox"/> Previous infection with <i>H. pylori</i> |
| <input type="checkbox"/> Frequent burping or bloating | <input type="checkbox"/> Gastroesophageal reflux (acid reflux) |
| <input type="checkbox"/> Regular use of alcohol or tobacco | |
| <input type="checkbox"/> Previous or current anti-inflammatory therapy (eg, aspirin, ibuprofen) | |

Section 8: *Yeast Syndrome (yeast dysbiosis)*

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|---|---|
| <input type="checkbox"/> Recent prolonged use of antibacterial or steroid drugs, or oral contraceptives | <input type="checkbox"/> Memory/concentration problems |
| <input type="checkbox"/> Sugar cravings | <input type="checkbox"/> Environmental/food sensitivities |
| <input type="checkbox"/> Hormone-related imbalances (PMS, hypoglycemia, etc) | <input type="checkbox"/> Recurrent skin rash or irritation |
| <input type="checkbox"/> Recurrent vaginal, prostate, or urinary infections | <input type="checkbox"/> Digestive problems (gas, bloating, stomach pain) |
| | <input type="checkbox"/> Chronic fatigue |