Symptom Checklist

"Your success with consistently reliable lab tests since 1978...guaranteed!"

If you have one or more of these symptoms, there's a 95% probability you'll benefit from a Bloodprint® food sensitivity test.

Please place a checkmark at each of your symptoms and return the completed checklist to your physician. Be sure to include symptoms that you've 'learned to live with'.

Digestive Tract
- ❑ Belching
- ❑ Bloated feeling
- ❑ Constipation
- ❑ Diarrhea
- ❑ Nausea
- ❑ Passing gas
- ❑ Stomach pains
- ❑ Vomiting

Ears
- ❑ Drainage from ear
- ❑ Ear aches
- ❑ Ear infections
- ❑ Hearing loss
- ❑ Itchy ears
- ❑ Ringing in ears

Emotions
- ❑ Aggressiveness
- ❑ Anxiety/fear
- ❑ Depression
- ❑ Irritability/anger
- ❑ Mood swings
- ❑ Nervousness

Energy & Activity
- ❑ Apathy
- ❑ Fatigue
- ❑ Hyperactivity
- ❑ Lethargy
- ❑ Restlessness
- ❑ Sluggishness

Eyes
- ❑ Blurred vision
- ❑ Dark circles
- ❑ Itchy eyes
- ❑ Sticky eyelids
- ❑ Swollen eyelids
- ❑ Watery eyes

Head
- ❑ Dizziness
- ❑ Faintness
- ❑ Headaches
- ❑ Insomnia
- ❑ Lightheadedness

Joint & Muscles
- ❑ Aches in muscles
- ❑ Arthritis
- ❑ Feeling of weakness
- ❑ Limited movement
- ❑ Pain in joints
- ❑ Stiffness

Lungs
- ❑ Asthma/bronchitis
- ❑ Chest congestion
- ❑ Difficulty breathing
- ❑ Shortness of breath
- ❑ Wheezing

Mind
- ❑ Confusion
- ❑ Learning disabilities
- ❑ Poor concentration
- ❑ Poor memory
- ❑ Stuttering/stammering

Mouth & Throat
- ❑ Canker sores
- ❑ Chronic coughing
- ❑ Gagging
- ❑ Often clear throat
- ❑ Sore throat
- ❑ Swollen tongue/lips/gums

Nose
- ❑ Excessive mucous
- ❑ Hay fever
- ❑ Sinus problems
- ❑ Sneezing attacks
- ❑ Stuffy nose

Skin
- ❑ Acne
- ❑ Dermatitis
- ❑ Eczema
- ❑ Excessive sweating
- ❑ Flushing/hot flashes
- ❑ Hair loss
- ❑ Hives/rashes
- ❑ Itching

Weight
- ❑ Binge eating
- ❑ Compulsive eating
- ❑ Cravings
- ❑ Excessive weight
- ❑ Underweight
- ❑ Water retention

Other
- ❑ Anaphylactic reactions
- ❑ Chest pains
- ❑ Frequent illness
- ❑ Genital itch
- ❑ Irregular heartbeat
- ❑ Rapid heartbeat
- ❑ Urgent urination

Patient's Name:_____ Phone #: _____

Email Address: _____

Address: _____

Weight: _____ Height: _____

During the last 30 days, have the symptoms you noted on the previous page...

1. Prevented you from getting a good night's sleep? ❑ Yes ❑ No

If yes, which symptoms?_____ How many nights? _____

2. Affected your performance at your place of employment? ❑ Yes ❑ No

If yes, which symptoms?_____ How many nights? _____

3. Caused you to call in sick to your place of employment? ❑ Yes ❑ No

If yes, which symptoms?_____ How many nights? _____

4. Caused you to leave your place of employment early? ❑ Yes ❑ No

If yes, which symptoms?_____ How many nights? _____

Do you or anyone in your family have a history of allergies? ❑ Yes ❑ No

Have you or has anyone in your family ever been to an allergist or been tested for allergies?

❑ Yes ❑ No

Do you have allergic reactions within 15 minutes or sooner after exposure to particular topical, ingested or inhaled substances such as:

- ❑ Animal danders
- ❑ Cosmetics
- ❑ Dust, pollen or mold
- ❑ Foods
- ❑ Insect stings
- ❑ Iodine
- ❑ Latex
- ❑ Laundry detergent
- ❑ Medicines
- ❑ Penicillin
- ❑ Plants or trees
- ❑ Shampoos and soaps
- ❑ Skin creams
- ❑ Sulfur

If so, can you identify the particular offending substance?

_____

Do you have severe, dramatic allergic reactions (anaphylaxis) with skin reactions, swelling, respiratory distress, and/or low blood pressure?

_____

If so, what causes it? (eg., bee stings, penicillin, etc.)

_____