



**Between 10 and 20 years of age :**

Infections ? ..... Which ones ? ..... Mononucleosis ? ..... Jaundice ?.....Hepatitis ?.....  
Surgical operations ? ..... Accidents ? .....  
Complaints in this period ? .....  
General health condition in this period ? .....  
Treatments ? ..... Teeth condition ? .....  
Military service ? ..... Gums condition ? .....

**Between 20 and 30 years of age :**

Infections ? ..... Which ones ? ..... Mononucleosis ? ..... Jaundice ?.....Hepatitis ?.....  
Surgical operations ? ..... Accidents ? .....  
Complaints in this period ? .....  
General health condition in this period ? .....  
Treatments ? ..... Teeth condition ? ..... Gums ? .....

**Between 30 and 40 years of age :**

Infections ? ..... Which ones ? ..... Mononucleosis ? ..... Jaundice ?.....Hepatitis ?.....  
Surgical operations ? ..... Accidents ? .....  
Complaints in this period ? .....  
General health condition in this period ? .....  
Treatments ? ..... Teeth condition ? ..... Gums ? .....

**Between 40 and 50 years of age :**

Infections ? ..... Which ones ? ..... Mononucleosis ? ..... Jaundice ?.....Hepatitis ?.....  
Surgical operations ? ..... Accidents ? .....  
Complaints in this period ? .....  
General health condition in this period ? .....  
Treatments ? ..... Teeth condition ? ..... Gums ? .....

**50 years and more :**

Infections ? ..... Which ones ? ..... Mononucleosis ? ..... Jaundice ?.....Hepatitis ?.....  
Surgical operations ? ..... Accidents ? .....  
Complaints in this period ? .....  
General health condition in this period ? .....  
Treatments ? ..... Teeth condition ? ..... Gums ? .....

**In your family** (grand-parents, parents, brothers, sisters, brothers and sisters of your parents, your children) please indicate any member of your family who suffers from the following (if yes, please indicate his or her relationship with you) :

obesity :  yes Who? ..... thinness :  yes Who? .....  
depression :  yes Who?..... epilepsy :  yes Who? .....  
migraine :  yes Who? ..... eczema :  yes Who? .....  
psoriasis:  yes Who?..... acne :  yes Who?.....  
lung emphysema :  yes Who? ..... chronic bronchitis :  yes Who? .....  
lung tuberculosis :  yes Who? ..... bedwetting :  yes Who? .....  
allergies :  yes Who? ..... goitre :  yes Who? .....  
high blood pressure :  yes Who P..... low blood pressure :  yes Who? .....  
rheumatism :  yes Who? ..... gout :  yes Who? .....  
heart attack :  yes Who?..... arteriosclerosis (legs) :  yes Who? .....  
stomach ulcer :  yes Who? ..... gallstones :  yes Who? .....  
juvenile diabetes :  yes Who? ..... maturity onset diabetes :  yes Who? .....  
early puberty (before age 12) :  yes ..... late puberty (after age 15) :  yes .....

**Remarks :**

Is your **husband, wife, partner**, suffering or has he/she suffered from one or more the above-mentioned affections ?    yes    no

Which ? .....

Are your **children** suffering or have they suffered from one or more the above-mentioned affections ?    yes    no

Were you on any medications ? .....

Previously ?    yes  no (if yes, which ones, dosage, when, for how long ?) .....

.....  
.....  
.....

Recently ?    yes    no (if yes, which ones, dosage, when, for how long ?) .....

.....  
.....  
.....

Please list the medications you are taking now : If so, name, dosage ?

Do you smoke ?    yes if yes, how many cigarettes a day ? .....

no

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**Important**

1. Please attach a colour photo of yourself.

2. Please take your **basal temperature** three times and record the result below. Put the thermometer under your armpit for 10 minutes in the morning, before getting up with as little movement as possible. Do not drink any alcohol the evening before. This test is not valid for women on birth-control pill (the pill increases body temperature).

T° : .....   T°: .....   T° : .....

3. Please include a photocopy of any recent blood work and/or laboratory tests.

Thank you for your cooperation.

Yours sincerely,

Dr Thierry Hertoghe

## 5 possible responses to the questions

	No Never	Few Sometimes	Moderately Regularly	A lot Often	Very much Always
<b>Please answer by ticking one box per question</b>	<b>0</b>	<b>±</b>	<b>+</b>	<b>++</b>	<b>+++</b>
1. Do you have a low resistance to stress ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you more tired in stressful situations ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you easily confused or drowsy, esp. during stress ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Is your blood pressure low ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have the impression of turnin around when you get up ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Are you down, tired, around 11 h or 16 h ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Are you attracted by sugar foods ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Are you attracted by salty foods (or spices) ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you suffer from digestive troubles (stomach or intestinal)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you have a poor appetite ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Are you thin (underweight) ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Do you suffer from inflammatory rheumatism (arthritis) ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Are you allergic :					
- skin allergy ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- nose / throat / ears ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- food allergies ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Do you suffer from asthma ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Do you tolerate badly medications ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Does your skin show broad brown spots of excessive pigmentation and/or broad white spots of depigmentation (vitiligo) ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-----					
1. Are you easily euphoric (too enthusiastic) ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you suffer from excessive agitation ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-----					
1. Are you tired when standing up and better laying flat ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you often have to urinate when you are standing up ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-----					
1. Is your sleep light, anxious, agitated ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you experience difficulties for going back to sleep (after awakening in the night) ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-----					
1. Is your skin peeling between your toes ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you suffer from moodswings ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you suffer from energy swings ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you suffer from a constant pressure on your head ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. For the ladies :					
- do you suffer from white vaginal discharge ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- do you suffer from premenstrual (malaise) ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- syndrome with breast tenderness ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## 5 possible responses to the questions

Please answer by ticking one box per question

	No Never	Few Sometimes	Moderately Regularly	A lot Often	Very much Always
<b>Do you have or feel the following symptoms ?</b>	<b>0</b>	<b>±</b>	<b>+</b>	<b>++</b>	<b>+++</b>
1. Sensitive to cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Cold in the evening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Cold hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. White dead fingers in the winter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Cold feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Increase need for blankets in the winter nights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. A poor blood circulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Tired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Tired when waking up in the morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Tired at rest, when not moving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Reduced vitality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Apathetic (lacking “punch”)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Sleepy during the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Slow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Distraction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Constantly depressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Headaches. If yes, where ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> around the eyes ?					
<input type="checkbox"/> at the side(s) of your head ?					
<input type="checkbox"/> at the back of the head ?					
<input type="checkbox"/> the wole head ?					
18. Migraines. If yes,with ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> nausea, vomiting ?					
<input type="checkbox"/> visual problems ?					
19. A poor memory (capacity to retain information)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. A poor concentration (capacity to remain attentive)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Nervous (tensed)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Irritable (aggressive)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Swollen :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- eyelids					
- puffy face	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. A tendancy to gain weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. A poor appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. An exaggerated appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

28. A slow / difficult digestion (heavy stomach)

No Few Moderately A lot Very much  
Never Sometimes Regularly Often Always

**5 possible responses to the questions**

Please answer by ticking one box per question

**Do you have or feel the following symptoms ?**

**O ± + ++ +++**

29. Intolerance to fats in your food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. Intolerance to chocolate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. Bedwetting as a child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. Nose bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. Slow heart palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34. Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. Muscle cramp at night : - in the feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- in the calves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- in the hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36. Carpel tunnel syndrome (tingling fingers)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
37. Stiff joints in the morning when getting out of bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38. Joint pains? Where? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
39. Joint pains worsened by cold or wet weather	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
40. A hoarse voice in the morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
41. Ear tingling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
42. Deafness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
43. Colds (nose)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
44. A sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
45. Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
46. A dry skin on : - the face	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- the elbows	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- the legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
47. A poor perspiration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
48. Brittle fingernails	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
49. Slow growing nails	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
50. Diffuse hair loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51. Slow growing hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
52. Poor urine losses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
53. Poor thirst (poor drinking)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
54. A permanent feeling of excessive heat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
55. Continuous excess sweating over the whole body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
56. Too thirsty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
57. Too hungry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
58. Excess weight loss despite eating much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
59. Abnormally anxious, aggressive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
60. Fast heart palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
61. A feeling of inner trembling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### 5 possible responses to the questions

Please answer by ticking one box per question

### Do you have or feel the following symptoms ?

	No Never <b>0</b>	Few Sometimes <b>±</b>	Moderately Regularly <b>+</b>	A lot Often <b>++</b>	Very much Always <b>+++</b>
1. Older looking physically	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Messy clothing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Less tonic (more) collapsed attitude	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Difficulties :					
- to read	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- to see at a distance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- a dim, foggy sight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Tooth abscesses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Loss of teeth (how many ? ....)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Wearing a tooth prothesis : above : ..... below : .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Heart pains at stress or exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Joint pains :					
- neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- middle back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- lower back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- finger / hands / wrist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- elbows	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- toes / hands / ankles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- knees	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- hips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. A permanent fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. A poor recovery after physical exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Less dynamic, more passive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Depressed the whole day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. A poor memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Hot flushes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Excessive sweating :					
- at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- during the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- at stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Dry eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Dry mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Dry vagina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## 5 possible responses to the questions

Please answer by ticking one box per question

### Do you have or feel the following symptoms ?

	No Never	Few Sometimes	Moderately Regularly	A lot Often	Very much Always
	O	±	+	++	+++
23. Pain at intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. A pale skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Wrinkles on :					
- the forehead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- around the eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- around the mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- on the palms of the hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Body hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. Hair loss on the upper scalp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. Small breasts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. Droopy, flaccid, deflated breasts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. Bladder infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. Urinary incontinence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. First menstruation :       ..... yrs					
<input type="checkbox"/> before 12 yrs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> before 12-15 yrs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> after 15 yrs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. Menopause, at what age :   ..... yrs					
<input type="checkbox"/> before 48 yrs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> before 48-52 yrs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> after 52 yrs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34. Irregular menstrual cycle :   ..... days					
<input type="checkbox"/> no (27-31 days)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> too short cycle (26 days or less)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Too long cycles (32 days or more)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. Depression in the days before menstruation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36. Mensutration with intermittent violent cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
37. Blood loss at menstruation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38. Ovulation pain (in the lower belly)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
39. Before your period :					
- painful swollen breasts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- painful swollen belly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- irritable, overexcited	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
40. Enlarged breasts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
41. Cysts in the breasts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
42. Cysts in the ovaries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
43. Fibroids in the uterus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
44. Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
45. Irritable (general)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
46. Anxious (lack of serenity)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
47. Too emotional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
48. Too rigid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
49. Low resistance to physical exercise (sports)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## 5 possible responses to the questions

Please answer by ticking one box per question

### Do you have or feel the following symptoms ?

	No Never	Few Sometimes	Moderately Regularly	A lot Often	Very much Always
	0	±	+	++	+++
50. Muscle loosening on : - the arms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- the legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51. Loss of muscle strenght	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
52. Excess fat on the : - breasts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- belly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- hips, buttocks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- thighs (cellulite)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
53. A skin which burns easily in the sun	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
54. Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
55. If yes, are they painful ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
56. Must stop walking because of pain in calves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
57. Ulcers at the ankles or toes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
58. Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
59. Easy bruises	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
60. Wounds healing difficulty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
61. Muscle loosening on : - the arms and legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- the belly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
62. Loss of muscle strenght	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
63. Joint pains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
64. Neck pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
65. Middle back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
66. Low back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
67. Joints pains in : - fingers/hands/wrists *	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- elbows	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- toes/feet/ankles *	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- knees	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- hips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
68. Hot flushes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
69. Intense sweating (when ? : night/day/stress *)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
70. Difficulties to urinate (poort urine flow)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
71. Loss of drops of urine after urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
72. Frequent needs to urinate : - during the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
73. At night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
74. Burning sensation while urinating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## 5 possible responses to the questions

Please answer by ticking one box per question

**Do you have or feel the following symptoms ?**

No Never	Few Sometimes	Moderately Regularly	A lot Often	Very much Always
<b>0</b>	<b>±</b>	<b>+</b>	<b>++</b>	<b>+++</b>

### For men :

1. Is your beard growing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have hair on your chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Loss of sexual potency (orgasm)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Loss of sexual desire (libido)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Loss of : - frequency of intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Urine incontinence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Swollen prostate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Fréquency of erections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Firmness erections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Duration of erections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Frequency of ejaculation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Volume of ejaculation (sperm)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### For women :

1. Do you have poor axillary or pubic hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have more body hair than desired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Are your breasts dropping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you suffer from premenstrual (malaise)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Syndrome with breast tenderness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Before your periods, are you irritable or depressive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Are your periods constantly painful	<input type="checkbox"/>	<b>yes</b>	<input type="checkbox"/>	<b>no</b>	
or constantly with violent cramps	<input type="checkbox"/>	<b>yes</b>	<input type="checkbox"/>	<b>no</b>	
8. Are your menstrual cycles irregular	<input type="checkbox"/>	<b>no</b> (27-31 days)	<input type="checkbox"/>	<b>too short cycles</b> (26 days or less)	<input type="checkbox"/>
				<b>too long cycles</b> (32 days or more)	
9. Do you suffer from white vaginal discharge ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Urine incontinence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Loss of sexual desire (libido)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Loss of sexual potency (orgasm)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## 5 possible responses to the questions

Please answer by ticking one box per question

	No Never	Few Sometimes	Moderately Regularly	A lot Often	Very much Always
<b>Do you have or feel the following symptoms ?</b>	<b>0</b>	<b>±</b>	<b>+</b>	<b>++</b>	<b>+++</b>
1. Thin(ner) hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Thin(ner) skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Nails with longitudinal lines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. A deeply wrinkled face	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Bags under the eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Sagging cheeks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Thin(ner) lips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Retracting gums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Thinned jaw(bone)s	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Loose skin folds under the chin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Your body silhouette sags down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Bowed back (more than before)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Weight loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Overweight (obesity)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Poorly (or less) muscled shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Dropping triceps (muscle at the back of the arm)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Poorly (or less) muscled & wrinkled hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Poorly (or less) muscled hips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Poorly (or less) muscled buttocks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Dropping inner sides of the thighs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Flabby, dropping belly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Fat cushions just above the knees	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Lower quality of life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. A poor health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Often sick	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Frequent infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. A poor appetie	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. A poor appetite for meat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. Muscles : - less tonic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- decreased volume	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- poor or decreased muscle strenght	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. Easily exhausted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. Constant tiredness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### 5 possible responses to the questions

Please answer by ticking one box per question

No      Few      Moderately      A lot      Very much  
 Never      Sometimes      Regularly      Often      Always

### Do you have or feel the following symptoms ?

**O**      **±**      **+**      **++**      **+++**

32. Difficulty to stay up late (after midnight)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. Difficulty to recover after staying up late (after midnight)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34. A need for a lot of sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. A low resistance to stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36. Difficulty recovery after a stressful situation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
37. Powerless or incompetent to cope with difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38. Not aggressive or assertive enough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
39. Too emotional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
40. A loss of sel-control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
41. Mood swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
42. A low self-esteem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
43. Anxious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
44. Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
45. Intolerance to cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
46. Thin muscles as a child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
47. Thin bones as a child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
48. A tendency to isolate socially, to stay at home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
49. A sharp voice, secreaming easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
50. A sharp verbal retorts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## 5 possible responses to the questions

Please answer by ticking one box per question

		No Never	Few Sometimes	Moderately Regularly	A lot Often	Very much Always
<b>Do you eat :</b>		<b>0</b>	<b>±</b>	<b>+</b>	<b>++</b>	<b>+++</b>
- <b><u>Milk products</u></b> :	- milk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	- buttermilk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	- yoghurt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	- cheese	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	- cottage cheese	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	- butter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- <b><u>Sugars</u></b> :	- white sugar, cane sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	- candies/sweets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	- chocolate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	- cakes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	- biscuits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	- jam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	- honey	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- <b><u>Fruits</u></b> :	- rich in fibres (orange, grape fruit, ...)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(1 piece a day = few)	- are they ripe when you eat them ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- <b><u>Vegetables</u></b> :		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you eat them :	- raw	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	- boiled	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	- cooked in oil or butter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	- as canned vegetables	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- <b><u>Cereals</u></b> :	- bread	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	- whole grain bread	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	- crackers, toasts,	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	- muesli	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	- pastas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	- sprouted germs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- <b><u>Corn flakes</u></b>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- <b><u>Animal protein</u></b> :	- generally	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	- meat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	- poultry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	- beef, pork or horse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you eat them :	- grilled or barbecued	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	- cooked in butter or oil	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## 5 possible responses to the questions

Please answer by ticking one box per question

	No Never	Few Sometimes	Moderately Regularly	A lot Often	Very much Always
<b>Do you eat :</b>	<b>O</b>	<b>±</b>	<b>+</b>	<b>++</b>	<b>+++</b>
Do you eat them :					
- in the oven	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- boiled or steamed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- raw	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- pork/butcher's meat (salami, smoked ham, ...)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>- Fish :</b>					
Do you eat it :					
- smoked	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- cooked in oil or butter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- boiled or steamed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- raw	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>- Sea food :</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>- Eggs :</b>					
- scrambled	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- boiled	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- raw	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>- Organic food :</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>- What do you drink :</b>					
- sugary drinks (soft drinks, tonics, ...)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- caffeinated drinks :					
- coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- cola	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- tea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- coffee derivatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- cereal, fruit coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- decaffeinated coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- alcoholic drinks :					
- beer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- strong alcohols (whisky, cognac)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- wine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- water :					
- sparkling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- plain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How much plain (non sparkling) water do you drink every day : ..... litres/gallons a day

### - What do you think about your food ?

- |   |  |
|---|--|
| - is it well balanced ? <input type="checkbox"/> yes <input type="checkbox"/> no                            | - do you eat little or much ? .....  |
| - do you drink little water or much ? .....   | - at irregular hours ? <input type="checkbox"/> yes <input type="checkbox"/> no              |
| - many dairy products ? <input type="checkbox"/> yes <input type="checkbox"/> no                            | - do you often eat in restaurants ? <input type="checkbox"/> yes <input type="checkbox"/> no |
| - do you cook your food at high temperature ? <input type="checkbox"/> yes <input type="checkbox"/> no      |  |
| - do you drink much beer, wine, alcoholic drinks ? <input type="checkbox"/> yes <input type="checkbox"/> no |  |

## 5 possible responses to the questions

Please answer by ticking one box per question

	No Never <b>0</b>	Few Sometimes <b>±</b>	Moderately Regularly <b>+</b>	A lot Often <b>++</b>	Very much Always <b>+++</b>
1. Do you have dandruff ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Is your hair itching ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have a coated tongue ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you suffer from a bloated belly ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you suffer from a lot of intestinal gazes ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you suffer alternatively from constipation and diarrhoea ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you suffer from peeling and/or itching red or white spots on your body (eczema, ...) ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Is the skin reddish and itching in the armpits, on the top of your thighs, between your buttocks ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you suffer from nettle rash ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Is your skin peeling between your toes ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you suffer from mood swings ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Do you suffer from energy swings ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Do you suffer from a constant pressure on your head ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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## QUESTIONNAIRE : POSSIBLE EXPOSURE TO TOXIC CHEMICALS

*Please answer the following questions pertaining to possible effects  
on your body from indoor and outdoor pollution*

---

### YOUR HOME

- |                           |  |                           |  |
|---------------------------|--|---------------------------|--|
| - in a town ?             | <input type="checkbox"/> yes <input type="checkbox"/> no | - in the country ?        | <input type="checkbox"/> yes <input type="checkbox"/> no |
| - in a village ?          | <input type="checkbox"/> yes <input type="checkbox"/> no | - in the centre ?         | <input type="checkbox"/> yes <input type="checkbox"/> no |
| - on the outskirts ?      | <input type="checkbox"/> yes <input type="checkbox"/> no |                           |  |
| - south from the centre ? | <input type="checkbox"/> yes <input type="checkbox"/> no | - north from the centre ? | <input type="checkbox"/> yes <input type="checkbox"/> no |
| - east from the centre ?  | <input type="checkbox"/> yes <input type="checkbox"/> no | - west from the centre ?  | <input type="checkbox"/> yes <input type="checkbox"/> no |
- Is there much traffic going past your home ?
- |            |  |
|------------|--|
| - cars ?   | <input type="checkbox"/> yes <input type="checkbox"/> no |
| - trucks ? | <input type="checkbox"/> yes <input type="checkbox"/> no |
| - buses ?  | <input type="checkbox"/> yes <input type="checkbox"/> no |
- Do you live on a corner or near a corner ?  yes  no
- Is there in the neighbourhood of your home :
- |                                |  |                       |  |
|--------------------------------|--|-----------------------|--|
| - a bus stop ?                 | <input type="checkbox"/> yes <input type="checkbox"/> no |                       |  |
| - traffic lights ?             | <input type="checkbox"/> yes <input type="checkbox"/> no |                       |  |
| - a main road ? how far : .... | <input type="checkbox"/> yes <input type="checkbox"/> no |                       |  |
| - public works ?               | <input type="checkbox"/> yes <input type="checkbox"/> no |                       |  |
| - a railway ?                  | <input type="checkbox"/> yes <input type="checkbox"/> no |                       |  |
| - trams ?                      | <input type="checkbox"/> yes <input type="checkbox"/> no |                       |  |
| - an airfield ?                | <input type="checkbox"/> yes <input type="checkbox"/> no |                       |  |
| - a school ?                   | <input type="checkbox"/> yes <input type="checkbox"/> no |                       |  |
| - a petrol station ?           | <input type="checkbox"/> yes <input type="checkbox"/> no |                       |  |
| - a garage ?                   | <input type="checkbox"/> yes <input type="checkbox"/> no |                       |  |
| - a coach works ?              | <input type="checkbox"/> yes <input type="checkbox"/> no | - with a pray booth ? | <input type="checkbox"/> yes <input type="checkbox"/> no |
| - an electricity stubstation ? | <input type="checkbox"/> yes <input type="checkbox"/> no |                       |  |
| - high-tension cables ?        | <input type="checkbox"/> yes <input type="checkbox"/> no | - how far ? .....     |  |
| - a stream or a river ?        | <input type="checkbox"/> yes <input type="checkbox"/> no | - does it smell ?     | <input type="checkbox"/> yes <input type="checkbox"/> no |
| - an industrial estate ?       | <input type="checkbox"/> yes <input type="checkbox"/> no |                       |  |
| - a factory(ies) ?             | <input type="checkbox"/> yes <input type="checkbox"/> no | - how far ? .....     |  |
| do they pollute ?              | <input type="checkbox"/> yes <input type="checkbox"/> no | - which one(s) .....  |  |
-

- Are you troubled by someone in your neighbourhood who burns :
  - waste material, wood, plastic, garden rubbish ?  yes  no
  - barbecue ?  yes  no
- Is the road past your house made with paving-stones or with asphalt ?  yes  no
- Are there near your home pastures :
  - fields ?  yes  no
  - greenhouses ?  yes  no
  - orchards ?  yes  no
  - cultivation of flowers ?  yes  no
  - cultivation of vegetables ?  yes  no
  - Do they spray with pesticides ?  yes  no

- Do you live :
  - in a house ?  yes  no - isolated  yes  no
  - in a row ?  yes  no
  - in an apartment ?  yes  no - which floor ? .....
  - is your home old ?  yes  no - or new ?  yes  no
  - how long have you lived there ? .....
  - and where before that ? .....

- Do you have much wood work in your home ?  yes  no
- where ? ..... (walls, floors, ceilings, ...)

Has the wood been treated with preservatives ?  yes  no

- Sadolin ?  yes  no - Linitop ?  yes  no - Xylamon ?  yes  no
- If yes, when ? .....

- Has painting been carried out in your home in the last years ?  yes  no
- with which paint ? ..... (oil paint, Latex, Stellatex, water soluble paint, acrylic paint, ...)

- Do you often use :
  - white spirit ?  yes  no - thinners ?  yes  no
  - turpentine ?  yes  no - Sadolin  yes  no
- (the old or the new one ?) .....

- The floor coverings in your home, what are they and where :
  - parquet ?  yes  no - wood strip ?  yes  no
  - vinyl ?  yes  no - Novilon ?  yes  no
  - linoleum ?  yes  no - stone ?  yes  no
  - fitted carpet ?  yes  no - synthetic or wool ?  yes  no

- 
- **Are the walls a covered with vinyl wallpaper ?**  yes  no
    - where ? .....
  - **Do you have ply or solid wood furniture ?**  yes  no
  - **What do you have on your bedroom floor ? :** .....
  - **on the walls ?** .....
  - are your blankets or quilts synthétic ?  yes  no
  - mattress ?  yes  no
  - pillows, foam or down ?  yes  no
  - do you have plastic lampshades ?  yes  no
  - **Are the curtains and hangings in the bedroom and dining room :**
    - synthétic ?  yes  no
    - cotton ?  yes  no
    - velvet ?  yes  no
  - **Is your bedroom immediatly under the roof ?**  yes  no
    - or is there an attic above ?  yes  no
- 

- **Roof :**
    - is the roof flat ?  yes  no
    - or pitched ?  yes  no
    - insulated ?  yes  no
    - with what ? .....
    - has the woodwork of the roof been treated with preservaties  yes  no
      - which ones ? .....
  - **Garage :**
    - is your garage included in house ?  yes  no
    - or separated ?  yes  no
    - is the garage sufficienly separated from the dining room ?  yes  no
  - **How is your home heated ?**  yes  no
    - central heating ?  yes  no
    - gas ?  yes  no
    - electric heating ?  yes  no
    - coal stoves ?  yes  no
    - open fireplace ?  yes  no
    - is it oil-fired ?  yes  no
    - is the boiler in a separate place?  yes  no
    - gas radiators ? How many ? .....
    - wood stovess ?  yes  no
  - **Kitchen :**
    - do you cook by gas ?  yes  no
    - or electricity ?  yes  no
    - can you ventilate your kitchen well ?  yes  no
  - **For drinking water, do you use bottles ?**  yes  no
    - plastic?  yes  no
    - or glass ?  yes  no
    - what do you know about the tap-water :
      - is it rich in calcium ?  yes  no
      - does it contain chlorine ?  yes  no
-

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- do you use it for tea, coffee, soup, boiling potatoes,... ?     yes     no

---

- **Do you smoke** ?     yes     no    - **How many** ? ...../day

- your husband, wife ?     yes     no

- your children ?     yes     no

- others around your ?     yes     no

- **Are you sensitive to** :

- perfume     yes     no

- cleaning products ?     yes     no

- ammoniac ?     yes     no

- bleach ?     yes     no

- bees wax ?     yes     no

- other ? .....

- **Allergies** : - do you suffer or have you suffered of hay fever ?     yes     no

- skin allergies ?     yes     no

- food allergies ?     yes     no

- other ? .....

- **Animals** : - do you have animals at home ?     yes     no

- cat(s) ?     yes     no

- dog(s) ?     yes     no

- bird(s) ?     yes     no

- other ? .....

- **Second home** : - do you have a second home ?     yes     no    - where ? .....

- chalet ?     yes     no

- wood construction ?     yes     no

- caravan ?     yes     no

- contry house ?     yes     no

---

- **How do you feel** : - by the sea ? .....

- in the mountains ? .....

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- **Car** : how many miles do you drive a year ? .....

- Do you ride a bicycle ?     yes     no

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- **Cosméticos** : - do you use cosmetics ?     yes     no

- which one(s) ? .....

.....

- do you use hair spray or dye ?     yes     no    - Which one(s) ? .....

- do you know the composition ? .....

---

- **Clothes** : do you wear : - many synthetic garments ?     yes     no

- rubber shoes or shoes with synthetic soles ?     yes     no

---

- a digital watch ?

yes  no

- do you often have your clothes dry-cleaned ?  yes  no

- **Teeth** : - do you have any dental fillings ?  yes  no - how many ? .....

- amalgams ?  yes  no - how many ? .....

- Have you orthopedic or other prostheses ?  yes  no

- wich one(s) ? .....

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### YOUR PROFESSION

- Which is or was your profession ? .....

- Where do or did you work :

- at home ?  yes  no - in industry ?  yes  no

- in a factory ?  yes  no - in a company ?  yes  no

- somewhere else ? .....

- Since how long do (did) you work there ? ..... - an before ? .....

- Do (did) you work in a town ?  yes  no - in the country ?  yes  no

- Do (did) you do manual work ?  yes  no - administrative work ?  yes  no

- Other ? .....

- Is there near your work :

- heavy traffic ?  yes  no

- a garage ?  yes  no

- a main road ?  yes  no

- a petrol station ?  yes  no

- an industrial estate ?  yes  no

- coach works ?  yes  no

- with a spray booth ?  yes  no

- a factory(ies) ?  yes  no

- a river or a stream ?  yes  no

- Do (did) you work with : - a computer ?  yes  no - a photocopymachine ?  yes  no

or did other people working near you ?  yes  no

- Do (did) you work in a room : - large ?  yes  no - or small ?  yes  no

Is (was) there a sufficient ventilation ?  yes  no - natural ?  yes  no

- with air-conditioning ?  yes  no - do (did) you suffer from it ?  yes  no

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- The floor coverings in your office/work place, what are they ? - parquet or wood strip ?  yes  no

- vinyl ?  yes  no - novilon ?  yes  no - linoléum ?  yes  no

- atone ?  yes  no - fitted carpet ?  yes  no - synthetic or wool ?  yes  no

---

---

- Are the walls covered with vinyl wallpaper ?       yes    no

- where ? .....

---

- Do you have ply furniture ?       yes    no                      - or solid wood furniture ?       yes    no

- Do (did) you work with dangerous products ?       yes    no

- do you use thinners ?       yes    no                      - white spirit ?       yes    no

- turpentine ?       yes    no                      - other ? .....

- Do (did) you smoke at work or did people smoke near your ?

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- Do you think you suffer from toxics in your environment ?       yes    no

- at home ?       yes    no

- at work ?       yes    no

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- Would you think pollution is a threat to your health ?       yes    no

- Are you well aware of problems of pollutions ?       yes    no

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**COLLECTION OF 24 HOURS URINE FOR THE  
ASSAY OF THYROID – SURRENAL AND SEX  
HORMONES, AND ELECTROLYTES**

**IMPORTANT : bring with you the 24 hours urines at the first consultation**

- The day and the evening prior to the recolte : calm activities, no sport or any other intense physical activity. Please avoid drinking excessive amounts of thee, coffee or cola, because this harms the precision of the assays. No vitamins during 8 days before collection.
- All urine of the day are kept cool, in the fridge if possible, until delivery to the laboratory.
- If the collection starts at 8 o'clock e.g., the urine of that time is not kept but all urines after that are, including the ones of 8 o'clock the next day.
- If by mishap some urines are lost, please restart the whole operation.
- If you have more urine than the bottles permit, the last ones can be kept in empty mineral water bottles.
- Do not collect 24 hrs urine during menstruations.

**Assayed in 24 hrs urine are :**

- Thyroid hormones (T3 and T4).
- Surrenal hormones (cortisol – free and derived, 17 keto – and 17OH-steroids).
- Sex hormones.
- Electrolytes (Na, K, Ca, P, Mg).

