Dear Patient or Parent:

You/your child will be undergoing testing for histamine sensitivity. In order to receive the most benefit from testing, your help and cooperation is essential. Please do not wear cologne or anything with any scent including tobacco smoke or fabric softeners. You will be unable to enter the testing room if you have any fragrances on. You will be required to take self or child’s pulse during the testing process. You will be asked to observed behavioral changes, changes in appearance, and any other symptoms patient may be experiencing. You will be given a timer to be set after each dose you/your child receives. Testing is done by intradermal injections. The timer will beep at five minute at which time you will need to take you/your child’s pulse for 15 seconds and record it on the symptoms sheet then you or your child must self sign his/her name. If your patient is too young to be able to write his/her name, you may have your child draw a picture. Have appropriate concentration work ready. Restart the timer for 5 minutes for concentration work. When the timer beeps after the five minutes have expired note any symptoms you observed or your child felt thought out the 10 mins. Next please send your child or self with his/her chart to the tester for evaluation and possible next injection. Your keeping accurate notes during the testing process will enable the tester to obtain the best results possible.

Our goal is to discover how these allergies affect you or your child’s ability to function. They will do skin testing for histamine and blood testing for individual foods and inhalants. We want the most for the patient. For some patients identifying theses sensitivities and treating them enables the patient to concentrate more easily, ease some of their frustrations, and yours, and help life to be more enjoyable.

If you have any questions or concerns during this process, please feel at ease to discuss them with the tester and/or Dr. Block. We look forward to having you and your child work with us to help make your testing experience a rewarding one.

Patients with asthma, please bring your rescue inhaler (albuterol, proventil) and peak flow meter if you have one.

YOU MUST SEE THAT THE PATIENT TAKES NO MULTI-VITAMINS, ANTIHISTAMINES, HERBS, OR HOMEOPATHIC DRUGS FOR ALLERGIES FOR ONE WEEK. NO STEROIDS/INHALERS FOR 30 DAYS. AND NO VITAMIN C FOR 72 HOURS PRIOR TO THE TESTING APPOINTMENT. You will be here for several hours so come dressed in a short sleeve shirt with a light jacket. Room temperature stays at 70 degrees. Please wear something with short sleeves. The testing will be done on their upper arm. The tester will be glad to teach you to take your child’s pulse. Please bring some school work or age appropriate concentration work for you/child to work on during testing so you can evaluate changes in his/her concentration. Please bring a mid morning and /or mid afternoon protein snack (nuts, eggs, meat, cheese) and water. We look forward to seeing you and your child in your testing department.

You will be here from 8:30am to 11:30am and then from 1:30pm to 3:00pm. Thank you.

___________________________________________
Signature

___________________________________________
Date
Please read and complete the following paperwork prior to your appointment at The Block Center

Please select the appropriate history form as well. The child’s form is for age birth to 18 years of age. The adult form is for over 18 years old.

The Block Center
PROVIDER NOTICE
OF INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and disclosures of health information

We seek your consent to use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. You can revoke your consent.

We may use or disclose identifiable health information about you without your authorization for several reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area and in each examination room. You can also request a copy of our notice at any time. For more information about our privacy practices, contact The Block Center.

Individual rights

In most cases, you have the right to look at or get a copy of health information about you that we use to make decisions about you. If you request copies, we will charge you $25.00 (twenty five dollars) for the first twenty pages, $0.50 (50 cents) for each page thereafter, and $9.40 to mail certified with return receipt. You also have the right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment or related administrative purposes. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact The Block Center You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

Our legal duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

If you have any questions or complaints, please contact:
The Block Center
1750 Norwood Drive
Hurst, Texas 76054
Phone: (817) 280-9933

I hereby declare that I have received and read the copy of The Block Center’s Provider Notice of Information Practices.

Patient’s printed name______________________________________________________________

Signature of patient or parent (if minor child) ___________________________________________

Date_________________________________________
The Block Center
1750 Norwood Drive, Hurst, TX 76054
817-280-9933

**IT IS IMPORTANT THAT YOU OR ANYONE COMING WITH YOU NOT WEAR ANY PERFUME, COLOGNE, AFTERSHAVE OR FRAGRANCES OF ANY KIND TO THE OFFICE. THIS ALSO INCLUDES TOBACCO ODORS, SHAMPOO, HAIR SPRAY AND FABRIC SOFTENER WITH FRAGRANCE. DUE TO THE SENSITIVITIES OF DR. BLOCK AND OTHERS IN OFFICE, YOU WILL BE UNABLE TO ENTER THE OFFICE IF YOU ARE WEARING ANY FRAGRANCE. IF YOU DO COME TO THE OFFICE WITH ANY FRAGRANCE ON, ARRIVE MORE THAN 15 MINUTES LATE OR DO NOT HAVE YOUR PAPERWORK FILLED OUT COMPLETELY, YOU WILL BE REQUIRED TO RESCHEDULE YOUR APPOINTMENT AND FORFEIT YOUR DEPOSIT.**

Payment is due at the time service are rendered and is payable by cash, check, MasterCard, or Visa.

We require 24 hours notice for rescheduling appointments. If you have any questions about your appointment please call during office hours so that we may clarify them prior to your visit.

We look forward to your visit.

I understand that The Block Center does not accept insurance for payment and that I am responsible for payment of all of my medical care. I understand that payment is due at the time of service.

If you will be filing claims with your insurance company you will need to sign an authorization to release information. Many times your insurance company will request more information from our office before they will process your claim. Please fill out the attached authorization with your insurance information. Without this signed consent we will be unable to release the information and your claim will not be processed. If your insurance company requests copies of your medical records, you will be billed for the cost of making the copies and mailing them to the insurance company. The charge approved by the State of Texas for this service is $25.00 for the first 20 pages and $0.50 for each page thereafter. There will also be fees for mailing the records. These fees include a certified fee, a returned receipt fee and the postage fee. These fees vary in price depending upon how much the copies weigh and the location or ‘zone’ they are being mailed to. We mail all medical records certified, return receipt so that we have proof that your insurance company did in fact receive your records.

Please initial below:

_____ I agree to have the Block Center mail copies of my medical records to my insurance company and I agree to pay the fees as outlined above each time my insurance company requests copies of my medical records.

_____ I do not want The Block Center to send copies of my medical records to my insurance company.

Signature of Patient or Responsible Party ___________________________ Date ___________________________
PATIENT RECORD OF DISCLOSURE

In general the HIPPA privacy rule gives patients the right to request on uses and disclosures of their protected health information (PHI). The patient is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual’s office instead of the individual’s home. This information will remain in effect until revoked in writing.

I wish to be contacted in the following manner (check all that apply):

- □ Home/Cell Telephone ___________________
- □ O.K. to leave message with detailed information
- □ Leave name/doctor with call back number only
- □ Work number ___________________
- □ Leave detailed message on work voice mail
- □ Leave name/doctor with call back number only
- □ When unable to contact me by phone, a written communication may be sent to my home address
- □ Other ___________________

Print name of patient ___________________ Birth Date ___________________

Signature of patient or guardian ___________________ Date ___________________

Healthcare providers must keep records of PHI disclosures.

Medicaid Release Information

I, ______________________, (Patient or parent/guardian of patient) understand that Dr. Mary Ann Block is not a Medicaid provider. I understand that my relationship with The Block Center is based on private pay and that I am responsible for all fees related to medical care. I understand that these fees are due at the time of service. I understand that no Medicaid claims will be or can be filed on my behalf for any services at The Block Center.

(Signature of patient or parent/guardian of patient) ___________________ Date ___________________
Dear Family:

You or your child will be undergoing various tests for either foods, inhalants or histamine sensitivities. In order to receive the most benefit from testing, your help and cooperation is essential. **Please do not wear cologne or anything with any scent including tobacco smoke or fabric softeners. You will be unable to enter the testing room if you have any fragrances on.** You will be required to take your child’s or your pulse during the testing process. You will be asked to observed behavioral changes, changes in appearance, and any other symptoms you or your child may be experiencing. You will be given a timer to be set after each dose you or your child receives. Testing is done by intradermal injections. The timer will beep at five minute at which time you will need to take you or your child’s pulse for 15 seconds and record it on the symptoms sheet then have your child sign his/her name or you will sign your name. If your child is too young to be able to write his/her name, you may have your child draw a picture. Have appropriate concentration work ready. Restart the timer for 5 minutes for concentration work. When the timer beeps after the five minutes have expired note any symptoms you observed or you or your child felt thought out the 10 minutes. Next please see the tester with your or your child’s chart for evaluation and possible next injection. Your keeping accurate notes during the testing process will enable the tester to obtain the best results possible.

Our goal is to discover what sensitivities your child has and how these sensitivities affect your child’s ability to function. We want the most for your child and you. For some children identifying these sensitivities and treating them enables the child to concentrate more easily, ease some of their frustrations, and yours, and help life to be more enjoyable.

If you have any questions or concerns during this process, please feel at ease to discuss them with the tester and/or Dr. Block.

We look forward to having you and your child work with us to help make your testing experience a rewarding one.

**YOU MUST SEE THAT YOU OR YOUR CHILD TAKE NO ANTIHISTAMINES OR HERBS, HOMEOPATHIC DRUGS FOR ALLERGIES FOR ONE WEEK OR VITAMIN C FOR 72 HOURS PRIOR TO THE TESTING APPOINTMENT.** You will be here for several hours so come dressed in warm comfortable clothes. Room temperature stays at 70 degrees. Please write down all the foods you or your child has eaten that day. Make sure you or your child have eaten 4 or 5 of the foods that you eat on a regular basis. We will either be testing these foods or histamine, so if you have certain foods you want tested, please be sure to speak to the tester about this. You or your child will need to wear something with short sleeves. The testing will be done on their upper arm. The tester will be glad to teach you to take your or your child’s pulse. Please bring some school work or age appropriate concentration work for you or your child to work on during testing so you can evaluate changes in concentration. Please bring a mid morning and /or mid afternoon protein snack (nuts, eggs, meat, cheese). We look forward to seeing you and your child in your testing department.

You will be here from 8:30am to 11:30am and then from 1:30pm to 4:00pm. Thank you.

Signature ____________________________ Date ______________

____________________________________
Name of Patient

____________________________________
Name of Parent or Guardian
New Patient Personal Information Sheet

**Personal Information:**

Date________________________

<table>
<thead>
<tr>
<th>Patient’s Full Legal Name</th>
<th>Sex</th>
<th>Birth Date</th>
<th>Race</th>
<th>Age</th>
<th>Marital Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>_________________________</td>
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<tr>
<th>Patient’s Social Security No.</th>
<th>Patient’s Driver’s License No.</th>
<th>Spouse’s Name</th>
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<tr>
<th>Patient’s Permanent Street Address</th>
<th>City/State</th>
<th>Zip Code</th>
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<td>_________________________</td>
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<th>Home Phone No.</th>
<th>Cell Phone No.</th>
<th>E-Mail Address</th>
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I give permission for The Block Center to send me information and updates. I understand that if I receive emails from The Block Center that I cannot contact The Block Center through this email address. It is for information sent to me only.

Signature __________________________ Date __________________________

**Financial Information:**

<table>
<thead>
<tr>
<th>Responsible Party Name (First)</th>
<th>(Middle)</th>
<th>(Last)</th>
<th>Telephone No./Ext</th>
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<th>Social Security No.</th>
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Please check the payment method you will be paying for your services:

( ) Cash  ( ) Check  ( ) Visa  ( ) Master Card

Credit card number for **phone appointments** or **supplement orders**

Exp date __________________________ Security Code __________________________

IN CASE OF EMERGENCY, NOTIFY:

Name __________________________ Phone Number __________________________

Email address __________________________
Today's Date______________________

This questionnaire is to help me evaluate your symptoms. This history is the single most important source of information about you. It is estimated that 70% of health problems can be solved from the history, 20% from the physical exam and 10% from lab and X-rays.

**General Information**

Name ____________________________________________________ Date of birth_________________________

Address_________________________________(City)_____________________(State)________(Zip)___________

Phone(_____)________________________________________ Age________________

Marital Status ____Single  ____Married _____ Divorced _____Separated _____Widow/Widower

Occupation________________________________________ Hobbies_______________________________________

Work History and Dates______________________________

____________________________________________________

____________________________________________________

Education: Years of High School _____ Years of College _____ Years of Post-graduate________________

List other countries where you have lived___________________________________________________________

List out of country travel________________________________________________________

1. How did you hear about The Block Center?___________________________________________________

2. Name of primary care physician____________________________________________________________

3. Describe problems which prompted you to call The Block Center:

   ___________________________________________ ___________________________________________

   ___________________________________________ ___________________________________________

   ___________________________________________ ___________________________________________

4. Have you tried other professionals for this complaint?_________If Yes, explain________________________

   ___________________________________________ ___________________________________________

5. Has child had any treatment for this problem?_______If Yes, explain________________________________

   ___________________________________________ ___________________________________________

6. What do you wish to accomplish?______________________________________________________________

   ___________________________________________ ___________________________________________
General Health Information

When and where was last physical exam? __________________________________________

List all prescription medications, over-the-counter medications and supplements currently taking:

<table>
<thead>
<tr>
<th>Name</th>
<th>Dose</th>
<th>Frequency</th>
<th>How Long Taking</th>
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Have you taken antibiotics or steroids in the past year? ____Yes  ____No

Do you take herbs? ____Yes  ____No                Do you now or ever, used tobacco in any form? ____Yes  ____No

Do you currently use tobacco? ____Yes  ____No  What kind? ___________________ How much? _______________

Do you currently drink alcohol? ____Yes  ____No, If yes, how often? _______________ How much? ____________

Do you currently use street drugs? ____Yes  ____No If yes, how often? _______________ How much? ____________

List any allergy to drugs with symptoms:

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<th>Drug</th>
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Check which applied to you when you were a child:

- ____Bothered by foods
- ____Poor Appetite
- ____Bottle Fed
- ____Behavior Problems
- ____Eczema
- ____Constipation
- ____Stomachaches
- ____Feeding Problems
- ____Headaches
- ____Hyperactivity
- ____Night Sweats
- ____Failure to Thrive
- ____Learning Problems
- ____Dyslexia
- ____Bedwetting
- ____Picky Eater
- ____Colic
- ____Hives
- ____Diarrhea
- ____Celiac Disease
- ____Constipation
- ____Skin Rashes
- ____Vomiting
- ____Leg Aches
- ____Gas
- ____Fussiness
- ____Food Allergies
- ____Other
- ____Other
- ____Other
- ____Other

Do you have a history of allergies or food intolerance?  ____Yes  ____No

Most meals eaten? ____at home  ____at restaurants
Do you feel better if you skip a meal?  ____Yes  ____No

Are there foods that make symptoms worse?  ____Yes  ____No  List:__________________________

Are there foods that make symptoms better?  ____Yes  ____No  List:__________________________

Do you often wake up at night? If Yes, do you eat or drink? What? __________________________

Have you ever fasted? If Yes, did you feel _____Better _____Worse _____Same

Are there foods you crave? If yes, list__________________________________________________

Are there any foods you binge on? If Yes, list___________________________________________

Do you have hypoglycemia?  ____Yes  ____No
When you go on vacation do you feel _____Better _____Worse

Do family members have allergies or food intolerances?  ____Yes  ____No

Which foods would you miss most if you could not eat them for several days?________________

Surgical History:

__________________________________________

__________________________________________

__________________________________________
In the last two years have you had any of the following?

- Sinus X-rays
- Chest X-rays
- Teeth X-rays
- Abdominal X-rays
- Brain Scan
- Bone Scan
- Body Scan
- Hearing Tests
- EKG
- Blood Tests
- Urine Tests
- TB Test
- Mammogram, If Yes, was it normal?  Yes  No
- Pap Smear, If Yes, was it normal?  Yes  No

What kind of doctors or specialists have you seen for your problems?

- Osteopath
- MD
- Psychologist
- Chiropractor
- Biofeedback
- Hypnosis
- Nutritionist
- Acupuncturist

Living Situation

Are you under stress?  Yes  No
Is your hostility easily aroused?  Yes  No
Are you 15 pounds or more overweight?  Yes  No
Do you have crying spells?  Yes  No
Are you usually happy?  Yes  No
Do you like your job?  Yes  No
Are you usually satisfied with medical advice?  Yes  No
Are you sad?  Yes  No
Do you exercise regularly?  Yes  No
Are you usually satisfied with medical advice?  Yes  No
Do you use strong smelling cleaning chemicals?  Yes  No
Do you use pesticides in your home?  Yes  No
Is your home treated regularly?  Yes  No
Do you use a lawn chemical company?  Yes  No
Do you have pets/animals?  Yes  No  Dog  Cat  Bird  Hamster  Rat  Horse  Rabbit  Guinea Pig  Other

Animals in the house?  Yes  No
Animals in the bedroom?  Yes  No

Is your pillow?  Feather  Down  Foam  Other

Is your mattress?  Foam  Box Spring  Futon  Waterbed  Plastic Covered  Other

Are your sheets and blankets?  100% Cotton  Wool  Synthetic  Other

Have you had any allergy testing?  Yes  No
If Yes, what type?  Skin  Blood

Are you taking any type of allergy treatment currently?  Yes  No
If yes, what?  Prescription  Over-the-counter  Allergy Injections  Avoidance

Have you been to emergency room for allergies or asthma?  Yes  No
How often?

Do symptoms flare when starting heating in the winter?  Yes  No  Worse?  Indoors  Outdoors

Symptoms flare when going to bed?  Yes  No
Do you have nasal symptoms?  Yes  No
Environment

Do you live in ____ House ____ Apartment ____ Other How long in this residence? ____________

Is garage attached ____ Yes ____ No Is there much vegetation (trees, weeds, etc.)? ____ Yes ____ No

Is there a lot of dust in the home? ____ Yes ____ No Does home have basement? ____ Yes ____ No

Is there mold/mildew in home? ____ Yes ____ No Is HVAC System? ____ Gas ____ Electric

Are your symptoms worse:

____ Outdoors ____ Indoors ____ Rainy Days ____ Windy Days

____ Fall ____ Summer ____ Spring ____ Winter

____ At Night ____ Weather Changes

Do you live near a power generating station/high voltage tower/transmitter? ____ Yes ____ No

Do you use electric blankets? ____ Yes ____ No Do you have indoor plants? ____ Yes ____ No

What kind of water do you drink? ____ Tap ____ Filtered ____ Plastic Bottled ____ Glass Bottled

Your Flooring Is: (Check all that apply) ____ Carpet/rugs ____ Wood ____ Tile ____ Vinyl ____ Cork

Review of Symptoms: Check those that apply:

Skin:

____ Eczema _____ Dry Skin _____ Oily Skin _____ Acne _____ Hives

____ Boils _____ Herpes _____ Split Nails _____ Easy Bruising _____ Face Swelling

Ear/Eyes/Nose/Throat:

____ Ears Ring ____ Dizziness ____ Hay Fever ____ Nasal Polyps ____ Ear Infections

____ Tubes in Ears ____ Mouth Sores ____ Sinus Infections ____ Post Nasal Drip ____ Hoarseness

____ Gums Bleed ____ Decayed Teeth ____ Glasses ____ Contacts ____ Cataracts

____ Glaucoma ____ Floaters ____ Night Blindness ____ Light Sensitive ____ Headaches

Headache Types: ____ Migraine ____ Sinus ____ Tension

Headache Symptoms: ____ Flushing ____ Nausea ____ Loss of Sight ____ Dazzling Lights

____ Neck Pain ____ Abdominal Pain ____ Vomiting ____ Visual Disturbance

Endocrine:

____ Fatigue ____ Hypothyroid ____ Hyperthyroid ____ Diabetes: ____ Type II ____ Type I

____ Hypoglycemia ____ Adrenal Fatigue
### Heart/Lungs:
- __Asthma__
- __Emphysema__
- __Bronchitis__
- __Cough__
- __Short of Breath__
- __Chest Pain__
- __Heart Attack__
- __Heart Murmura__
- __Abnormal EKG__
- __Heart Races__
- __Heart Skips__
- __Ankles Swell__

### Gastrointestinal:
- __Abdominal Pain__
- __Nausea__
- __Vomiting__
- __Gall Stones__
- __Vomited Blood__
- __Ulcer__
- __Heartburn__
- __Bloating__
- __Cramps__
- __Laxative Use__
- __Diarrhea__
- __Constipation__
- __Anal Itching__
- __Hepatitis__
- __Blood in Stool__
- __Belching__
- __Gas__
- __Regular Antacid Use__
- __Black Bowel Movements__

### Urinary Tract:
- __Burning__
- __Urgency__
- __Blood in Urine__
- __Kidney Stones__
- __Kidney Disease__
- __Lose Urine When Coughs/Sneezes__
- __Bladder/Kidney Infections__
- __Hard to Start Urine__
- __Kidney Disease__
- __Void Small Amounts Urine Each Time You Go__

### Gynecology: (Females Only) At the time of your period, check all that apply:
- __Fluid Retention__
- __Cramps__
- __PMS__
- __Depressed__
- __Irritable__
- __Heavy Bleeding__
- __Appetite Change__
- __Irregular Flow__
- __Irregular Period__
- __Vaginal itching__
- __Yeast Infection__
- __Vaginal Itching__
- __Vaginal Discharge__
- __Bleeding Between Periods__
- __Menopause, If yes, What Age?__
- __Vaginal Bleeding Since Menopause__
- __Pregnant__
- __Birth Control, If Yes, What Kind?__

Date of last PAP Smear______________________________
Date of last period __________________________________

### Men Only: Check all that apply:
- __Lump in Testicle__
- __Discharge from Penis__
- __Sores on Penis/Scrotum__
- __Painful Erection__
- __Inability to Sustain Erection__
- __You do not examine testicles monthly__

### Blood:
- __Low White Count__
- __Anemia (Low Red Blood Count)__
- __Easy Bruising__
- __Takes Iron__
- __Easy Bleeding__
- __Lymph Gland Swelling__
Musculo-skeletal:

- Rheumatoid Arthritis
- Osteoarthritis
- Gout
- Muscle Spasms
- Joint Swelling
- Muscle Fatigue
- Restless Legs
- Painful Joints
- Swollen Joints
- Red Joints
- Neck Pain
- Other Pain

Neurology:

- Head Injury
- Blackout Spells
- Headaches
- Seizures
- Numbness
- Tingling
- Lost Ability to Speak
- Lost Ability to Move
- Dyslexia
- Trouble Thinking
- Learning Disabilities
- Trouble in School
- Memory Loss
- Trouble Explaining What You Mean
IMMEDIATE FAMILY
Instructions: Please include all information you know related to the following areas.
You may need to ask your parents for a complete history.

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<th>Maternal</th>
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<td>Sister</td>
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| Age if living |  |
| Age at death |  |
| Cause of death |  |
| Type of work |  |

Mark an "X" for any positive answer

- Asthma
- Allergy Hives
- Eczema
- Hayfever
- Weight Problem
- Smokers
- Alcohol Abuse
- Mental illness
- Cancer
- Diabetes
- Hypertension
- Heart problem
- High cholesterol
- Thyroid disease
- Blood disease
- Bowel problem
- Ulcers
- Arthritis
- Migraines
- Other
**Diet Diary:** List all food and drinks typically eaten in a normal week. Include all snacks, fast food and drinks.

### Sunday:

**Breakfast:**

**Morning Snack:**

**Lunch:**

**Afternoon Snack:**

**Dinner:**

**Evening Snack:**

### Monday:

**Breakfast:**

**Morning Snack:**

**Lunch:**

**Afternoon Snack:**

**Dinner:**

**Evening Snack:**
Diet Diary Continued: List all food and drinks typically eaten in a normal week. Include all snacks, fast food and drinks.

Tuesday:

Breakfast:__________________________________________________________

Morning Snack:______________________________________________________

Lunch:______________________________________________________________

Afternoon Snack:_____________________________________________________

Dinner:______________________________________________________________

Evening Snack:_______________________________________________________

Wednesday:

Breakfast:__________________________________________________________

Morning Snack:______________________________________________________

Lunch:______________________________________________________________

Afternoon Snack:_____________________________________________________

Dinner:______________________________________________________________

Evening Snack:_______________________________________________________
Diet Diary Continued: List all food and drinks typically eaten in a normal week. Include all snacks, fast food and drinks.

Thursday:

- Breakfast:__________________________________________________
- Morning Snack:______________________________________________
- Lunch:______________________________________________________
- Afternoon Snack:____________________________________________
- Dinner:______________________________________________________
- Evening Snack:_______________________________________________

Friday:

- Breakfast:__________________________________________________
- Morning Snack:______________________________________________
- Lunch:______________________________________________________
- Afternoon Snack:____________________________________________
- Dinner:______________________________________________________
- Evening Snack:_______________________________________________
Diet Diary Continued: List all food and drinks typically eaten in a normal week. Include all snacks, fast food and drinks.

Saturday:

Breakfast: _____________________________________________________________

_______________________________________________________________

Morning Snack:_____________________________________________________

_______________________________________________________________

Lunch: ____________________________________________________________

_______________________________________________________________

Afternoon Snack:___________________________________________________

_______________________________________________________________

Dinner: ____________________________________________________________

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Evening Snack:_____________________________________________________

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Favorite Foods:____________________________________________________

_______________________________________________________________

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<th>3X WEEK</th>
<th>1-2X WEEK</th>
<th>Seldom</th>
<th>Never</th>
<th>C/RLA/OV/VE/E</th>
<th>Like</th>
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