Master Fast System (MFS) Health Questionnaire

Client Information

Name		**Height**		**Weight**		**Sex**	
Address		**City**		**Province**		**Postal Code**	
Date of Birth			**Eye Color**				
Email Address			**Phone Number**				
Employment			**Family Physician**				

What is your body telling you?

Please type "X" under Yes or No or add a number Yes for certain questions & add comments as necessary. If there are any questions that you do not know the answer to, you may leave them blank.

Yes	*No*	*Gastrointestinal (GI) Tract*
		73. Is your tongue coated, especially in the morning? 1-*white, 2-yellow, 3-green or 4-brown*?
		74. Do you have a hiatus hernia?
		75. Do you have gastritis?
		76. Do you have enteritis?
		77. Do you have colitis?
		78. Do you have diverticulitis?
		79. Do you get or have diarrhoea?
		80. Do you have or get constipation? How many times do you move bowels per day or week? _____ per day or _____ per week
		81. Have you ever had stomach or intestinal ulcers?
		82. Do you or have you ever had any type of gastrointestinal cancers: stomach, colon, rectal, etc.? Please specify: _____
		83. Do you have Crohn's Disease?
		84. Do you have "gas" issues?
		85. Do you have other gastrointestinal problems? What kind? _____

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Yes	*No*	***Kidneys & Bladder***
		137. Have you ever had a urinary tract infection (*UTI*)?
		138. Have you ever had "burning" upon urination?
		139. Do you have problems holding your bladder (*parathyroid*)?
		140. Have you ever had kidney stones?
		141. Do you have bags under your eyes (*esp. in the morning*)?
		142. Is your urine flow restricted?
		143. Do you get cramping or pain on either side of your mid-to-lower back?
		144. Do you or did you ever have nephritis?
		145. Do you or did you ever have cystitis?

Yes	*No*	***Lymphatic System***
		117. Have you ever had lymph nodes removed?
		118. Do you ever get colds or flu-like symptoms?
		119. Do you have or get sinus problems?
		120. Do you have or get sore throats?
		121. Do you have or get swollen lymph nodes?
		122. Do you have or have you had tumours? What type? 1-fatty, 2-benign, or 3-malignant?
		123. Do you have a low platelet count (blood)?
		124. Is your immune system weak or sluggish?
		125. Have you had appendicitis or an appendectomy? When? _____
		126. Do you get boils, pimples, cysts, etc.?
		127. Do you get regular exercise? How many times per week? _____
		128. Have you ever had abscesses?
		129. Have you ever had toxaemia?
		130. Do you have or have you had cellulitis?
		131. Have you ever had gout?
		132. Do you get blurred vision?
		133. Do you have mucus in your eyes when you wake up in the morning?
		134. Do you snore?
		135. Do you have sleep apnoea?
		136. Have you had your tonsils out? At what age? _____

Yes	*No*	***Thyroid/Parathyroid (Glandular System)***
		1. Are you over weight?
		2. Do you get cold hands and feet?
		3. Do you have hair loss, are you bald, or going bald?
		4. Is it easy to put on weight and hard to lose it?

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		5. Are your fingernails 1-ridged, 2-brittle, or 3-weak?
		6. Do you have varicose or spider veins?
		7. Have you had 1-hemorrhoids or 2-prolapsed organs?
		8. Do you get cramping in your muscles?
		9. Do you have a weak bladder?
		10. Do you have an irregular heartbeat?
		11. Do you have mitral valve prolapse (*heart murmur*)?
		12. Do you get headaches or migraines?
		13. Have you ever had a hernia?
		14. Have you ever had an aneurysm?
		15. Do you have osteoporosis?
		16. Do you have scoliosis?
		17. Do you get irritable easily?
		18. Do you have low energy levels?
		19. Do you suffer from symptoms of depression?
		20. Did you score low on your bone density tests?
		21. Do your tests come back showing low calcium levels?
		22. Do you have or have you ever had a goiter?
		23. Do you have spine deterioration, herniated discs, or bone spurs?
		24. Have you or any family member been diagnosed with Hashimoto or Riedel disease?
		25. Do you sweat profusely?

Yes	***No***	***Adrenal Glands – Medulla***
		26. Do you have 1-M.S., 2-Parkinson's, or 2-Palsy?
		27. Do you have *anxiety attacks* or feel *overly anxious*?
		28. Do you feel *excessive shyness* or feel *inferior* to others?
		29. Do you have 1-high or 2-low Blood Pressure? Systolic: _____/Diastolic: _____
		30. Do you have tremors, nervous legs, etc.?
		31. Do you have tinnitus (*ringing in the ears*)?
		32. Do you have shortness of breath or is it hard to take a deep breath?
		33. Do you have heart arrhythmias?
		34. Do you have a hard time sleeping or insomnia?
		35. Do you have chronic fatigue syndrome?
		36. Have you ever been diagnosed with Addison's disease or congenital adrenal hyperplasia?

Yes	***No***	***Adrenal Glands – Cortex***
		37. Do you have elevated blood cholesterol levels?
		38. Do you have lower back weakness?

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		39. Do you have or have you had sciatica?
		40. Do you have any inflammatory conditions “itis’s”?
		41. If yes, please indicate which inflammatory condition(s) you have *(e.g. arthritis, rheumatoid arthritis, bursitis, enteritis, colitis, phlebitis, neuritis, etc.)* _____
		42. Do you have low cortisol or steroids levels?

Yes	***No***	***Female Only***
		43. Are your menstruations irregular?
		44. Do you get excessive bleeding during menstruation?
		45. Do you have or have you ever had ovarian cysts?
		46. Do you have or have you ever had uterine fibroids?
		47. Do you have or have you ever had endometriosis or A-typical cells?
		48. Do you have or have you ever had fibrocystic breasts?
		49. Do you have or have you ever had fibromyalgia or scleroderma?
		50. Do you get sore breasts, especially during menstruation?
		51. Do you have a 1-low or 2-excessive sex drive?
		52. Have you had a hysterectomy? When? _____ Was it 1-Partial or 2-Complete? _____ Did they take any other organs out at the same time *(e.g. gallbladder)*? Please indicate: _____
		53. Have you had a D & C?
		54. Have you had a miscarriage?
		55. Have you had challenges conceiving children?
		56. Have you been on Birth Control Pills? For how long? _____

Yes	***No***	***Male Only***
		57. Do you have prostatitis (*frequent urination, esp. at night*)? How often do you urinate? _____
		58. Do you have prostate cancer? PSA count: _____
		59. Do you have testicular hypertrophy (*enlargement*)?
		60. Do you have a 1-low or 2-excessive sex drive?
		61. Do you have erection issues?
		62. Do you have premature ejaculation?

Yes	***No***	***Pancreas***
		63. Do you get gas after you eat?
		64. Do you feel your foods are just sitting in your stomach?
		65. Do you have acid reflux?
		66. Do you see undigested food in your stool?
		67. Do you have hypoglycaemia (*low blood sugar*)?

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		68. Do you have diabetes (*high blood sugar*)? Type 1 or Type 2?
		69. Are you very thin and have a hard time putting on weight?
		70. Do you have gastritis or enteritis?
		71. Do your foods pass right through you (*diarrhoea*)?
		72. Do you have moles on your body? (Adrenal & pancreatic weakness)

Yes	***No***	***Liver/Gallbladder/Blood***
		86. Do you have a problem digesting fats?
		87. Do fats or dairy foods cause bloating and/or pain in the stomach area?
		88. Are your stools white or very light brown in color?
		89. Do you get pain in the middle of your back (*especially after eating*)?
		90. Do you get pain behind the right, lower rib area?
		91. Do you have "liver" or brown spots on your skin? (*not freckles*)
		92. Do you have any skin pigmentation changes?
		93. Do you have skin issues? What type? _____
		94. Are you or have you ever been anaemic?
		95. Do you have or have you ever had hepatitis? If yes, what type? (A, B, or C)? _____

Yes	***No***	***Skin***
		109. Do you get or have skin rashes?
		110. Do you get skin blemishes?
		111. Do you have eczema or dermatitis?
		112. Do you have psoriasis?
		113. Do you itch anywhere? Where? _____
		114. Is your skin dry?
		115. Is your skin excessively oily?
		116. Do you get or have dandruff?

Yes	***No***	***Lungs***
		146. Do you get, have, or have had, bronchitis?
		147. Do you get, have, or have had, emphysema?
		148. Do you get, have, or have had, asthma?
		149. Do you get, have, or have had, C.O.P.D?
		150. Are you on inhalers or nebulizers? What type? _____ How often? _____
		151. What is your oxygen saturation level? _____
		152. Do you get pain when you breathe?
		153. Do you get pain when you take a deep breath?
		154. Do you have or have you ever had lung cancer?

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		155. Do you have a collapsed lung?
		156. Are you a smoker? If yes, how often? _____
		157. Have you ever had pneumonia?
		158. Have you ever worked around toxic chemicals, in coal mines or around Asbestos?
		159. Do you cough a lot?
		160. Do you get any mucus when you cough?
		161. What color is the mucus? 1-clear, 2-yellow, 3-green, 4-brown, or 5-black? _____

Yes	***No***	***Heart & Circulation***
		96. Do you have any gray hair?
		97. Do you have a hard time remembering things?
		98. Do your legs get tired or cramp after you walk?
		99. Do you bruise easily?
		100. Do you get chest pains or angina?
		101. Have you ever had a heart attack (*myocardial infarction*)?
		102. Have you ever had open-heart surgery?
		103. Do you have heart arrhythmia? What kind? _____
		104. Do you have a heart murmur or mitral valve prolapse?
		105. Do you ever feel pressure on your chest?
		106. Do you get "prickly" pains anywhere, especially in the heart area? Where? _____
		107. Do you have or have you ever had high blood pressure?
		108. Do you have a pacemaker or stents? Please specify: _____

Yes	***No***	***Environmental Toxins***
		162. Have you been vaccinated or had shots for traveling to foreign countries?
		163. Have you had regular flue shots?
		164. Do you have mercury amalgams?
		165. Have you been exposed to nuclear wastes or by-products, heavy metals, or chemicals?
		166. Have you had any 1-radiation or 2-chemotherapy? If yes, please specify: _____ How many treatments? _____

167. What are your main health complaints or concerns? - Please list any conditions or symptoms that this questionnaire has not covered or asked you.

_____
_____
_____

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168. Past Surgeries - Please list any past surgeries you have had (*e.g. tonsils removed, hysterectomy, open heart surgery, etc.).*

Surgery	*Year of Surgery*

169. Chemical Medications - *Please list any medications you are presently taking.*

Name	*Reason for Taking*

170. Natural Supplements - *Please list any natural supplements you are currently taking.*

Name	*Reason for Taking*

171. Allergies – *Please list anything that you are allergic to:*

_____
_____
_____

172: Genetic History – *(what health issues did they have…)*

Mother: _____
Father: _____
(Maternal) Grandfather: _____
(Maternal) Grandmother: _____
(Paternal) Grandfather: _____
(Paternal) Grandmother: _____
Sisters: _____
Sisters: _____
Brothers: _____
Brothers: _____

Once you have completed the Health Questionnaire, please email it to gino@masterfastsystem.com