Heavy Metals Toxicity Questionnaire

Patient (your name, or if this is your child, the child's name)			
Patient's first name	Middle name	Last name	Last 4 digits of Soc. Sec. Number XXX-XX- _______

Instructions

Listed below are symptoms often found in patients who have absorbed excessive amounts of Heavy Metals: These poisonous metals include Lead, Mercury, Aluminum, Arsenic and Cadmium. All are found in modern environments.

Even if you have many of the symptoms below, you may not be Heavy Metal Toxic — there may be other causes. Certain combinations of symptoms are more accurate indicators.

The best available diagnostic tool to determine Heavy Metal Toxicity is a Urine Challenge Test for Heavy Metals. We offer this test through our office.

If you checked a dozen or more symptoms - or have significant exposures - you may have problems with Heavy Metals Toxicity. Visit our website, www.VaughanIntegrative.com, to make an appointment for a follow-up with a physician knowlegeable in Heavy Metals Toxicities.

Symptom List

- ☐ Anxiety or depression
- ☐ ADHD/ADD
- ☐ Learning disorders
- ☐ Poor memory
- ☐ Confusion or forgetfulness
- ☐ Numbness in hands, arms, feet or legs
- ☐ Tingling or pricking sensations
- ☐ Muscle weakness
- ☐ Burning pain (especially at night)
- ☐ Paralysis
- ☐ Arthritis
- ☐ Auto-immune disease
- ☐ Neuropathy
- ☐ Scleroderma
- ☐ Psoriasis
- ☐ Lupus
- ☐ Thyroid problems
- ☐ Irritability
- ☐ Protein in urine
- ☐ Miscarriage
- ☐ Nervousness (jumpy, jittery)
- ☐ Exaggerated response to stimulation
- ☐ Frequent urination at night
- ☐ Chronic fatigue; lack of energy
- ☐ Feeling cold when others don't
- ☐ Bloating
- ☐ Constipation, chronic
- ☐ Shaking or tremors
- ☐ Leg cramps, frequently
- ☐ Muscle twitching
- ☐ Ringing in the ears (tinnitus)
- ☐ Itching a lot
- ☐ Sore gums (gingivitis)
- ☐ TMJ (temporal mandibular joint ailment)
- ☐ Lowered sperm production
- ☐ Lowered libido (less sex drive)
- ☐ Eye irritation
- ☐ Birth defects
- ☐ Chest pain
- ☐ Excessive salivation
- ☐ Tearing (eyes watering)
- ☐ Anemia
- ☐ Emphysema
- ☐ Osteoporosis
- ☐ Liver damage (diagnosed)
- ☐ Infertility
- ☐ Cancer (particularly lung or skin)
- ☐ Loss of sense of smell
- ☐ Metallic taste in mouth
- ☐ Thirsty a lot
- ☐ Pale face or pale eyes
- ☐ Blurred vision, loss of vision
- ☐ Leukopenia
- ☐ Bad breath, "Garlic Breath"
- ☐ Brown spots or age spots on skin
- ☐ PVC's (cardiac arrhythmia caused by Premature Ventricular Contractions)
- ☐ Raynaud's Syndrome (fingers or toes turn pale, then blue)
- ☐ More colds and flu, or other infections, than you think is normal
- ☐ Food allergies or sensitivities
- ☐ Numbness or burning in mouth or gums
- ☐ Problems walking or balancing
- ☐ White tongue (Thrush)
- ☐ Problems sleeping
- ☐ Kidney problems
- ☐ Emotional instability
- ☐ Many health problems, but "they say they can't find anything wrong."
- ☐ ALS (Amyotrophic Lateral Sclerosis)
- ☐ Cardiac problems
- ☐ Congestive Heart Failure
- ☐ Lung irritation
- ☐ Emotional instability
- ☐ Shyness or timidity
- ☐ Mood swings
- ☐ Rocking movements
- ☐ Confusion
- ☐ Burning in throat
- ☐ Inflammation of the lining of the nose
- ☐ Difficulty walking
- ☐ Difficulty talking
- ☐ Abdominal cramps
- ☐ Stomach problems
- ☐ Chronic diarrhea
- ☐ Low blood pressure*
- ☐ High blood pressure*
- ☐ Increased heart rate
- ☐ Hearing loss, hearing difficulties
- ☐ Chronic headaches
- ☐ Skin rashes
- ☐ Cold, clammy skin, especially hands or feet
- ☐ Excessive sweating
- ☐ Loss of appetite
- ☐ Joint pain
- ☐ Nausea or vomiting
- ☐ Fluid retention
- ☐ Irritable bowel/colitis

* High and Low Blood Pressure problems sometimes related to different metals.

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Patient (your name, or if this is your child, the child's name)			
Patient's first name	Middle name	Last name	Last 4 digits of Soc. Sec. Number XXX-XX- ______

Street address (not Post Office Box)	City	State	Zip Code	Date today MM/DD/YYYY

Date of Birth MM/DD/YYYY	Age	Gender	Marital Status
		☐ Male ☐ Female	☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Widow(er)ed ☐ Partnered

Guardian or Authorized Representative (If patient is under age 18 or adjudged incompetent.)

If you are not the patient, check one: I am the patient's ☐ legal next of kin ☐ legal guardian ☐ authorized representative.

Guardian's/Rep's first name	Middle name	Last name	Last 4 digits of Soc. Sec. Number XXX-XX- ______

How can we reach you? (Check the telephone number you prefer us to call. We cannot discuss the results by email.)

Work phone ☐	Extension	Home phone ☐	Mobile phone ☐	Best time to call	Email address

Tell us about your work and environmental exposures. Check those that apply.

Have you worked in manufacturing or fabricating ☐ metals ☐ plastics ☐ petroleum ☐ rubber ☐ textiles ☐ glass ☐ ceramics ☐ paper ☐ electronics ☐ hot-type printing ☐ batteries ☐ fiberglass?

Have you been significantly exposed to ☐ fertilizers ☐ pesticides ☐ rodenticides ☐ herbicides ☐ fungicides ☐ paints and thinners ☐ wood preservatives ☐ batteries ☐ alloys ☐ dyes ?

Have you done health service maintenance ☐ chemical processing ☐ electroplating ☐ soldering ☐ welding ☐ metal cutting ☐ leather tanning ☐ fireworks ☐ metal smelting (copper, lead, zinc, etc.) ☐ photographic darkroom work?

Have you ever lived or worked near a ☐ coal-burning power plant (like Belews Creek) ☐ mercury mine ☐ nickel refinery ☐ golf course ☐ chloralkali plant ☐ phosphate mine ☐ apple or peach orchard or tobacco farm?

Have you ever had Candida-Related Complex (CRC) or yeast infections? ☐ No ☐ Yes

Have you ever had 10 or more silver-colored fillings in your teeth? ☐ No ☐ Yes Have you ever worked in a dental office? ☐ No ☐ Yes

Do you ☐ take mineral supplements ☐ use traditional or herbal medicines ☐ eat seafood more than three times a month?

Do you smoke cigarettes? ☐ Never smoked ☐ Smoke now, about ____ packs a ☐ day ☐ week ☐ Quit (when)

If you smoked, how long? About ____ years. How much? About ____ packs a ☐ day ☐ week.

Other tobacco use: ☐ Pipe ☐ Cigars ☐ Snuff ☐ Chew Are you exposed to second-hand smoke? ☐ No ☐ Yes

Have you built a deck or other structure, using pressure-treated lumber that was manufactured before 2003? ☐ No ☐ Yes

Do you get your water from a well? ☐ No ☐ Yes Do you have old water pipes in your house? ☐ No ☐ Yes

Have you lived in a house built before 1978? ☐ No ☐ Yes Have you ever renovated an old house? ☐ No ☐ Yes

Tell us about your relatives' health. Has a blood relative had any of the following? If so, check and show exact relationship: Your mother, father, brother or sister; your mother's mother, father, brother or sister; your father's mother, father, brother or sister. If person adopted, note that.

Disease or illness	Relationship	Disease or illness	Relationship
☐ Alzheimer's Disease, dementia		☐ Cardiovascular disease	
☐ Autism Spectrum Disorder		☐ Mental problems	
☐ Cancer		☐ Parkinson's Disease	

Does your child have problems with intelligence, concentration or language development? ☐ No ☐ Yes

Please sign below	Section below reserved for physician	
Your signature	Reviewed by physician (signature)	Date reviewed MM/DD/YYYY

If you checked a dozen or more symptoms — or have significant exposures — you may have problems with Heavy Metals Toxicity. Review at, www.VaughanIntegrativeMedicine.com, to see whether you wish to be further evaluated by us. Send completed questionnaire only after you have a confirmed appointment.

How to send us your completed questionnaire:

1. Print the form on your printer
2. Fax the form to (336) 808-3628 (Voice line: 808-3627) ...OR...
3. Mail the form to Vaughan Integrative Medicine, Suite A, 1301 W. Wendover Avenue, Greensboro, NC 27408

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