

TOXICITY QUESTIONNAIRE

©1997 HealthComm International, Inc. and Immuno Laboratories, Inc. Permission to reprint R9/12/97

Rate the following symptoms based upon your health profile for the past thirty days

- Point scale**
- 0 - *Never* or *almost never* have the symptom
 - 1 - *Occasionally* have it, effect is *not severe*
 - 2 - *Occasionally* have it, effect is *severe*
 - 3 - *Frequently* have it, effect is *not severe*
 - 4 - *Frequently* have it, effect is *severe*

HEAD

- Headaches
- Faintness
- Dizziness
- Insomnia

Total _____

EYES

- Watery or itchy eyes
- Swollen, reddened, or sticky eyelids
- Bags or dark circles under eyes
- Blurred or tunnel vision (does not include near- or far-sightedness)

Total _____

EARS

- Itchy ears
- Earaches, ear infections
- Drainage from ear
- Ringing in ears, hearing loss

Total _____

NOSE

- Stuffy nose
- Sinus problems
- Hay fever
- Sneezing attacks
- Excessive mucus formation

Total _____

MOUTH / THROAT

- Chronic coughing
- Gagging, frequent need to clear throat
- Sore throat, hoarseness, loss of voice
- Swollen or discolored tongue, gums, lips
- Canker sores

Total _____

SKIN

- Acne
- Hives, rashes, dry skin
- Hair loss
- Flushing, hot flashes
- Excessive sweating

Total _____

HEART

- Irregular or skipped heartbeat
- Rapid or pounding heartbeat
- Chest pain

Total _____

